

00-09360

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These please remove carbon copies. Pages 1 and 2 should be filed with the local health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, the death certificate must be signed by the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 17471	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Dorothy Louise Appel			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR MIN.		
DOROTHY GUYTON APPEL						6 11 86			907 A M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		March 3, 1911		75 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Fallston, Md.		USA				HARFORD MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
FALLSTON		FALLSTON GENERAL HOSPITAL									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Housewife		---									
13a. STATE			13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland			Harford		Fallston				2828 Harford Road 21047		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Carl Elijah Guyton					Esley Eladora Kyle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS						
no			---		Forest Hill, Md. 21050 Sandra L. Mink, 1002 Bernadette Drive,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>83</u> , to <u>FEB 28</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>FEB 28</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. Reinhardt Jr. Dr. Vassar</u>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN				
Burial			June 13, 1986		Fork U.M. Cemetery		Fork Balto. Md.				
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Howard K. McComas III, Abingdon, Md. 21009							JUN 13 1986		<u>J. Davidson-Randall</u>		

BP _____



00-11007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17472

REG. NO.

FOR
STATE
REGISTRAR (William Harold Archer)

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST WILLIAM HAROLD ARCHER		2a. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1986		2b. HOUR 10 50 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR October 2, 1939		6. AGE (IN YEARS LAST BIRTHDAY) 46	
7. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.	
10. CITY OR TOWN OF DEATH (20078) Baltimore de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Chemical Mfg.	
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Churchville (21028)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6 Bramble Lane 21028		14. FATHER'S NAME FIRST MIDDLE LAST Harold MELVIN Archer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Esther Briney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES-NAVY		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1957-1961		17. INFORMANT (WIFE) 734-6200 Mrs. Barbara J. Archer		ADDRESS 6 Bramble Lane Churchville, Maryland 21028	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PROBABLE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/23/86 to 6/23/86, that (I) (we) last saw the deceased alive on 6/23/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John P. Edwards		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Edwards		22e. ADDRESS Bel Air, MD 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville, Harford Co, Maryland 21028	
24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St Baltimore, Maryland 21014				25a. DATE REC'D. BY REGISTRAR JUN 26 1986		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assigned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

Received from the

James H. H.

Handwritten notes and markings on the left margin, including several checkmarks and illegible text.

Main body of handwritten text, appearing to be a letter or report, with several lines of cursive script.



00-09922

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 17473	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard V. Boles						2a. DATE OF DEATH MONTH DAY YEAR June 10, 1986			2b. HOUR 2:00P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.					
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 33 old Sound Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) I.R. S. Agent		12b. KIND OF BUSINESS OR INDUSTRY Int. Revenue			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Joppatowne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 33 Old Sound Rd. 21085			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Boles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Daly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-45		17. INFORMANT Mrs. Margaret Boles		ADDRESS 33 Old Sound rd. Joppatowne, Md. 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1st January</u> 19 <u>86</u> , to <u>10 June</u> 19 <u>86</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>13th May</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Raymond E. Knowles Jr. M.D.</u>						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11th June 1986	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Raymond E. Knowles Jr M.D.</u>						22e. ADDRESS <u>1011 North Charles St Balto Md. 21201</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-13-1986		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet. Cen.			23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087						25a. DATE REC'D. BY REGISTRAR JUN 16 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

RECEIVED

1900

THE
CITY
OF
NEW YORK

OFFICE
OF THE
COMMISSIONER
OF THE
LAND OFFICE

00-09382

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17474

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Arthur H. Brown			2a. DATE OF DEATH MONTH DAY YEAR 6 12 86		2b. HOUR M 1P						
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 2 1909		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS 77		IF UNDER 24 HRS HOURS MIN. 1P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) B.R.L.		12b. KIND OF BUSINESS OR INDUSTRY APG			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1445 Perryville Road 21903			
14. FATHER'S NAME FIRST MIDDLE LAST John F. Brown Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah A. Hasson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-14-0339		17. INFORMANT ADDRESS Mabel T. Brown 1445 Perryville Rd. 21903					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/9 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6/9 1986 6/12 86					
22a. I certify that (I) (this hospital) attended the deceased from 6/12 1986 to 6/12 1986 , that (I) (we) last saw the deceased alive on 6/12 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante Munkil						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/12/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MUNKIL						22e. ADDRESS 622 S. Union Ave Harford, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 15, 1986		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit Cecil Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Lee A. Patterson & Son Perryville, Maryland						25a. DATE REC'D. BY REGISTRAR JUN 13 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner will be notified.

BP

UNITED STATES
NAVY
OFFICE
OF THE
CHIEF OF
NAVY
BUILDING
WASHINGTON, D.C.



James S. [illegible]
[illegible]
[illegible]

00-11251

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17475

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Joseph</i> <i>CARL</i> <i>Buettner, JR.</i>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 19 <i>6-30-1986</i>		2b. HOUR M 6A
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 10 37	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 47	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6-30-1986
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
7c. CITY OR TOWN OF DEATH <i>Chaire de Grace</i>		7d. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem. Hospital</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Hartford</i> COUNTY, MD.	
10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. CITY BALTIMORE		
13c. ZIP CODE 21234			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH C. BUETTNER, SR.</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARY E. KERNAN</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. <i>215-34-5513</i>		17. INFORMANT ADDRESS <i>MARY E. BUETTNER BALTO., MD 21234</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Luis E. Renjel</i>		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED <i>6-30-86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E Renjel</i>		ADDRESS <i>464 a llave st Havana</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE <i>JULY 3, '86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>GARRISON FOREST VETERANS BALTIMORE CO., MD</i>	
24. FUNERAL DIRECTOR NAME <i>WILLIAM E. JOHNSON</i>		ADDRESS <i>8521 LOCH RAVEN BLVD</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 2 1986</i>	
		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXCLUDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3-RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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00-10383

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86 17476 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Elizabeth (nmn) BYRNE					2a. DATE OF DEATH MONTH DAY YEAR JUNE 21, '86					2b. HOUR 6p ^{xx} _M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 13 18			6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philadelphia, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD				
10. CITY OR TOWN OF DEATH Abingdon		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2987 Harrowgate Way					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2987 Harrowgate Way 21009		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas --- Magee					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary --- Casey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 197-01-5826		17. INFORMANT ADDRESS Abingdon, Md. 21009 Edmund C. Byrne, 2987 Harrowgate Way						
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Respiratory Failure with End Stage Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Congestive heart failure / Cor Pulmonale - Same- PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Asthma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 pm 6/21/86 x 3 yrs	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE PARK, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from FEB. 18, 19 84 to MAY 17, 19 86 that (1) we last saw the deceased alive on MAY 17, 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did (did not) view the body after death											
22b. SIGNATURE Albert S. C. Sun, M.D.					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED June 22, '86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S. C. SUN, M.D.					22e. ADDRESS 1800 Harford Rd, Fallston, MD 21047						
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE June 25, 1986		23c. NAME OF CEMETERY OR CREMATORY U.S. National Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Burlington Beverly N.J.			
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR JUN 24 1986		25b. REGISTRAR'S SIGNATURE J. H. Davidson			

00-10303

Elizabeth

June 21, 84

Frank White

Harford

X



George W. White
Frank White
Harford

George W. White



Feb 18 84

George W. White
Frank White
Harford

00-09078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 4 7 7

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER NMN CHAPMAN			2a. DATE OF DEATH MONTH DAY YEAR JUNE 8, 1986		2b. HOUR M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 19, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY, MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4055 WILKINSON ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMPLOYED	12b. KIND OF BUSINESS OR INDUSTRY CARPENTER
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD	13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4055 WILKINSON ROAD 21078	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES E. CHAPMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH O. STARR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 218 18 0009		17. INFORMANT ADDRESS MRS. MILDRED P. CHAPMAN SAME AS #13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Esophagus junction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>with reflux</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

MEDICAL CERTIFICATION

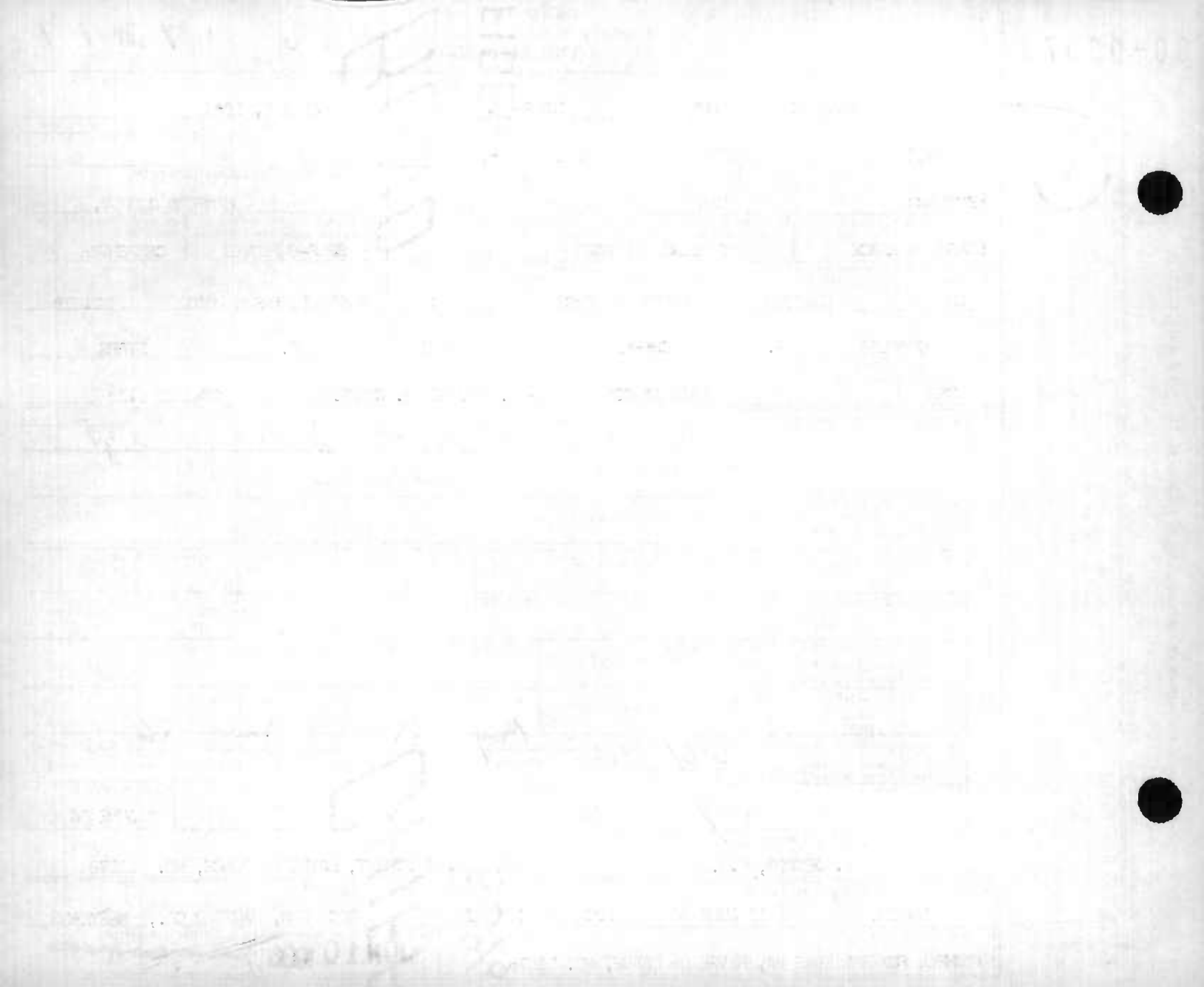
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1400 19 85 to June 86	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/6/86</u> to <u>6/8/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>M. Jesada</u>	DEGREE M.D.	ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9 JUNE 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. JESADA, M.D.		22e. ADDRESS 433 GIRARD STREET, HAVRE de GRACE, MD. 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 13 JUNE 86	23c. NAME OF CEMETERY OR CREMATORY ROCK RUN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE ROCK RUN, HARFORD CO., MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 10 1986 <u>John Anderson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



9
0-11794
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 3 FOR 10 YEARS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#18, 21a cdef, 22a, FilmG618										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17478																													
1. FOR REGISTRAR 8/15/86 kam																																																											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE OF DEATH										2b. HOUR																																							
NELLIE L. Clay										DATE KNOWN OF DEATH ESTIMATED XX 6-28 19 86										7b. HOUR 8:30 a. m.																																							
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH MAY 11, 1931										6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.										7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.										8. DATE PRONOUNCED DEAD 6-28 19 86									
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND										10. CITIZEN OF WHAT COUNTRY? USA										11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										12. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.																													
13. CITY OR TOWN OF DEATH Harve de Grace										14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 201 N. FREEDOM LANE, Apt. 3										15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER										16. KIND OF BUSINESS OR INDUSTRY																													
17a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. CITY OR TOWN HARFORD										13c. CITY OR TOWN HAVRE de GRACE										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 201 N. FREEDOM LANE APT. 3 21078																			
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD MILLING										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVIEVE JENNINGS																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 214 32 9749										17. INFORMANT ADDRESS DONNA MYERS 426 WEBB LANE, HAVRE de GRACE, MD 21078																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) Drug Abuse																																																											
DUE TO, OR AS A CONSEQUENCE OF																																																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																																											
(b) DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6/28 1986										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject used drug																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home										21f. LOCATION CITY OR TOWN COUNTY STATE Md. 200 N. Union Ave., Apt. 3, Havre de Grace																																							
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																	
ACTUAL SIGNATURE Dennis F. Smyth, M.D.										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 6-28-86																																							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.										ADDRESS 111 Penn St., Balto., Md. 21201																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 1 JULY 86										23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY										23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.																													
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078										ADDRESS										25a. DATE REC'D. BY REGISTRAR JUL 1 1988										25b. REGISTRAR'S SIGNATURE Julia Anderson-Rudner																													

RECEIVED
JAN 11 1964

12711-6

RECEIVED
JAN 11 1964

RECEIVED
JAN 11 1964

00-09278

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8617479	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD NEWTON COAN						2a. DATE OF DEATH MONTH DAY YEAR June 10, 1986			2b. HOUR 10:45 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York, N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 752 Schofield Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Engr.			12b. KIND OF BUSINESS OR INDUSTRY NASA		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 752 Schofield Road 21001			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Allan Coan, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth --- Freethy				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 028-10-2375				17. INFORMANT Robert A. Coan, III, 752 Schofield Road				ADDRESS Aberdeen, Md. 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic renal failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic cardiovascular disease										years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 19 83, to June 10, 19 86, that (I) (we) lost saw the deceased alive on May 25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Nicholas J. Fortuin M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-11-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nicholas J. Fortuin, M.D.						22e. ADDRESS 9 E. Chase St, Baltimore, Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 14, 1986		23c. NAME OF CEMETERY OR CREMATORY Cemetery Our Lady of the Field		23d. LOCATION CITY OR TOWN COUNTY STATE Millersville A.A. Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009						25a. DATE REC'D. BY REGISTRAR JUN 12 1986		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

00-11025

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD., 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Charles

C.

Cochran

2a. DATE KNOWN
OF DEATH
ESTIMATED

MONTH DAY YEAR
6-22 1986

2b. HOUR
4 35 PM

3 SEX
M

4 RACE
W

5. DATE OF BIRTH
MONTH DAY YEAR
March 21 1912

6. AGE (IN YEARS
LAST BIRTHDAY)
74 RS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN.

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
6-22 1986

2d. HOUR
4 35 PM

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Pennsylvania

7b. CITIZEN OF WHAT COUNTRY?

United States

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Harford County,

MD

10. CITY OR TOWN OF DEATH

Fallston

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Fallston General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Electrician

12b. KIND OF BUSINESS
OR INDUSTRY

Construction

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Harford

13c. CITY OR TOWN

Whiteford

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS

1521 Kerr Road/21160

14. FATHER'S NAME
FIRST MIDDLE LAST

Charles

A.

Cochran

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

Margie

Hess

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

162-05-5898

17. INFORMANT

ADDRESS

Carolyn G. Cochran 1521 Kerr Road Whiteford, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)
DUE TO, OR AS A CONSEQUENCE OF

ASUDD

(c)
DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL
SIGNATURE

Luis E. Renjel

TITLE (SPECIFY)

M.D. Deputy

MEDICAL EXAMINER

DATE

SIGNED 6-23-86

EXAMINER'S NAME
(TYPE OR PRINT)

Luis. E. Renjel, M.D.

ADDRESS

464 Alliance ST. Havre De Grace, MD

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

6/25/86

23c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

23d. LOCATION
CITY OR TOWN

Pylesville

COUNTY

Harford

STATE

MD

24. FUNERAL DIRECTOR
NAME

ADDRESS

John Harkins 600 Main Street Delta, PA 17314

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

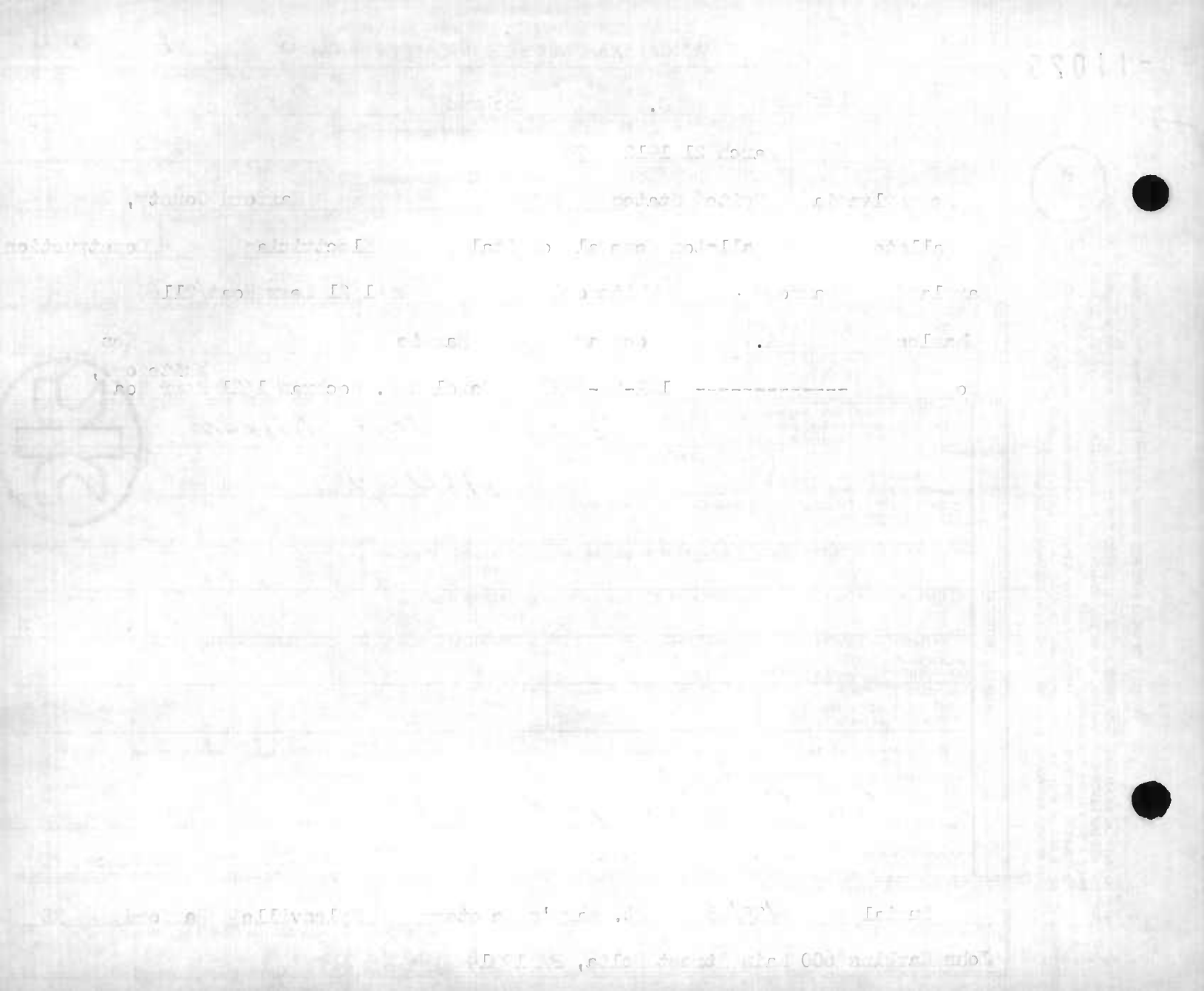
JUN 25 1986

Luis E. Renjel

07/84
25M

BP

DMMH - 17
(VR A15 ME (5))



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and send them within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

72-00-11222

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										86		17481	
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CLYDE ROBERT CONNORS					2a. DATE OF DEATH MONTH DAY YEAR 6 27 86					2b. HOUR 7:45 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3/29/1926			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.						
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming				
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4747 Norrisville Road 21161					
14. FATHER'S NAME FIRST MIDDLE LAST Harry C. Connors					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannette Cloeman								
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 216-28-2856		17. INFORMANT ADDRESS Mary Brown Connors, White Hall, Md. 21161						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Dysrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE George Laws MD					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/27/86				
23a. PHYSICIAN'S NAME (TYPE OR PRINT) George Laws MD					23e. ADDRESS 651								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/30/1986		23c. NAME OF CEMETERY OR CREMATORY Ayres Chapel Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE White Hall, Harford, Md.					
24. FUNERAL DIRECTOR NAME K.W. Orsburn F.H., Inc.					24b. ADDRESS Stewartstown, Pa.		25a. DATE REC'D. BY REGISTRAR JUL 23 1986		25b. REGISTRAR'S SIGNATURE Jim [Signature]				

00-11521

XX

NOTICE

NOTICE

NOTICE



00-10879

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DEWEY PLATO DANCY			2a. DATE OF DEATH MONTH DAY YEAR June 27, 1986		2b. HOUR 9:40 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 21, 1928		
6. AGE (IN YEARS LAST BIRTHDAY) 58		7. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		9b. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		10. CITY OR TOWN OF DEATH Fallston		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 310 Nilles Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator		12b. KIND OF BUSINESS OR INDUSTRY Shoe		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		
14. FATHER'S NAME FIRST MIDDLE LAST Dewey -- Dancy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie -- Johnson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korea		
16b. SOCIAL SECURITY NO. 208-22-3270		17. INFORMANT ADDRESS Md. 21047 Betty I. Dancy, 310 Nilles Lane, Fallston.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR MONITARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA of THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 6-28-86	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				22c. DATE SIGNED 6-28-86			
22b. SIGNATURE <u>Joan P. Edwards</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-28-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joan P. Edwards, M.D.				22e. ADDRESS 2112 Belair Road, Fallston, Md. 21047			

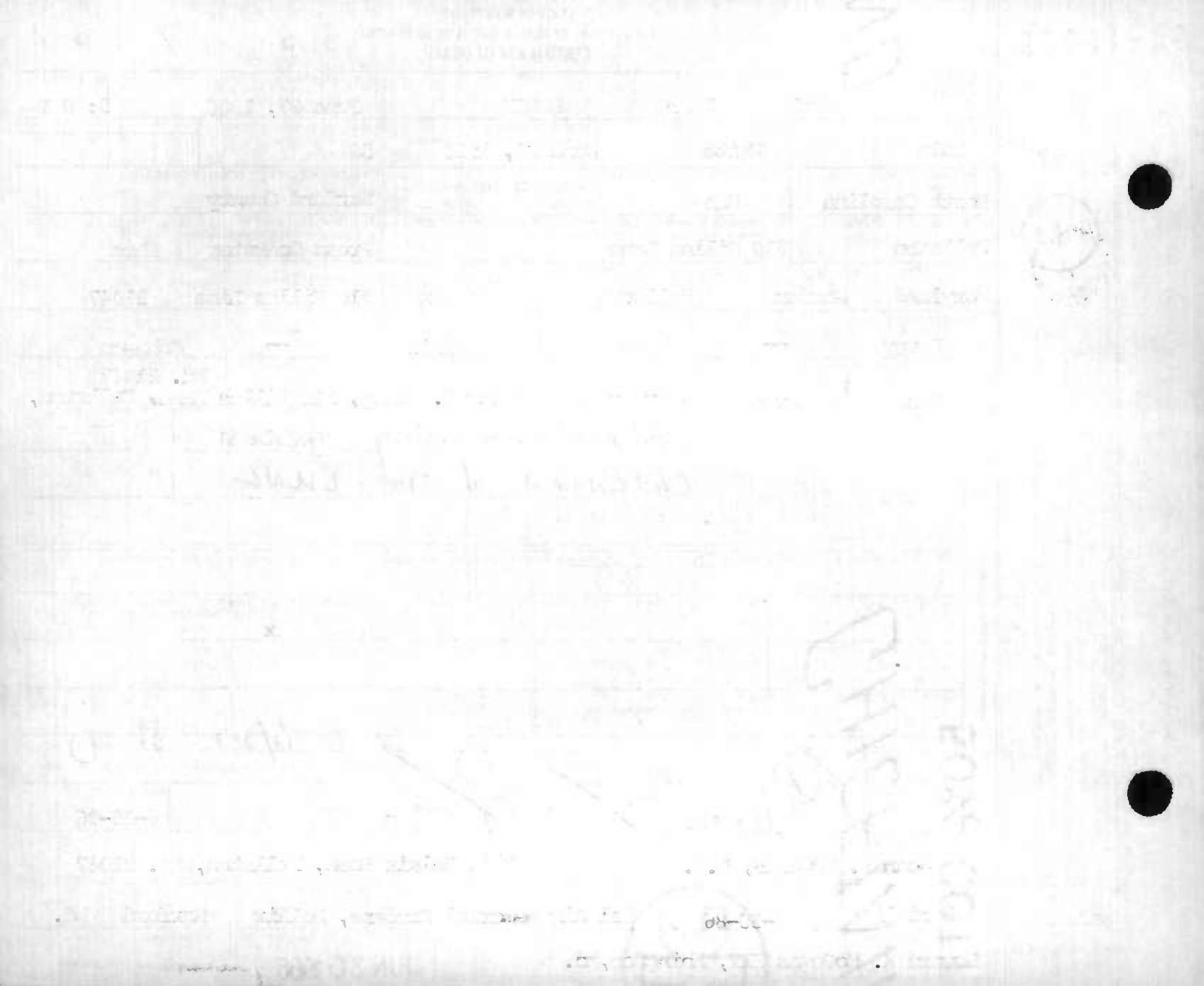
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-30-86		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air		23d. LOCATION CITY OR TOWN COUNTY STATE Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR JUN 30 1986		25b. REGISTRAR'S SIGNATURE <u>Una Anderson-Pondale</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.



00-11502

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17483

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Delmar E Devonshire			2a. DATE OF DEATH MONTH DAY YEAR June 30, 1986		2b. HOUR 12 MIN 35	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 27 1900		
6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U. S. A		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) constoian		
12b. KIND OF BUSINESS OR INDUSTRY 6047		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 221 Polittown Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN F. DEVONSHIRE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA MATSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-078458		17. INFORMANT ADDRESS MAIRIE BANNISTER (SAME AS 13 ABOVE)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. and Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 1983					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chronic Lymphocytic Leukemia Since 1983						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HOLD MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6-30-86 to 6-30-86 , that (I) (we) last saw the deceased alive on 6-30-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.						
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.		22c. DATE SIGNED 6/30/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D.		22e. ADDRESS Havre de Grace, Md. 21078				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-3-86		23c. NAME OF CEMETERY OR CREMATORY PLEASANT GROVE		
23d. LOCATION CITY OR TOWN COUNTY STATE POTOMAC BOTTOM LANCASTER PA		24. FUNERAL DIRECTOR Richard L. Goodie		25a. DATE REC'D. BY REGISTRAR JUL 7 1986		
25b. REGISTRAR'S SIGNATURE John Davidson						

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use in the burial permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner will be needed at death.

BP

0-21205

DMOZ

0501

NOV 10 1950

MINA



00-08553

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17484
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert M Durbin			2a. DATE OF DEATH MONTH DAY YEAR 6 4 86			2b. HOUR 8:29 AM			
3. SEX MALE		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR MAR 25, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Bldg Ed.	
13a. STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 408 S. Stokes St 21078	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY DURBIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA MOSES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-01-4042			17. INFORMANT ADDRESS Julie R. Hawkins, Harford Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) RENAL FAILURE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/6 19 86, to 6/4 19 86, that (I) (we) last saw the deceased alive on 6/4 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dante Monakil						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/4/86	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL						23b. ADDRESS Harre de Grace, Md 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE June 9-86		23c. NAME OF CEMETERY OR CREMATORY St. James U. Cem.		23d. LOCATION Harre de Grace, Harford County, Md		
24. FUNERAL DIRECTOR Chela J. Bullock						25a. DATE REC'D. BY REGISTRAR JUN 5 1986		25b. REGISTRAR'S SIGNATURE Kathleen R. Riddle	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

2228000

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified of this.

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 6 1 7 4 8 5	
1. STATE 6/30/86 rjd		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NORMA (nmn) EPPERLY		2a. DATE OF DEATH MONTH DAY YEAR 6/24/86		2b. HOUR 1:20 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 20, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
13a. STATE Maryland		13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Luther (nmn) Clark		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie -- Farley		17. INFORMANT ADDRESS Gay S. Whitely, 1513 Cochran Road, Joppa, Md. 21085	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 232-84-6379		17. INFORMANT ADDRESS 21085	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiomyopathy					
(c) Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/15 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6/15 1986		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6/24 1986	
22a. I certify that (I) (this hospital) attended the deceased from 6/15 1986 to 6/24 1986 , that (I) (we) last saw the deceased alive on 6/15 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE Dante Monakil		DEGREE		22. DATE SIGNED 6/24/86	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL		22a. ADDRESS Harre deBona md 21078		22b. REGISTRAR'S SIGNATURE J. A. ...	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JUN 26 1986		25b. REGISTRAR'S SIGNATURE J. A. ...	

BP

1000 MINTHILL

13847 NOTION 6500

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00-09276

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17486
REG. NO.

1- FOR STATE REGISTRAR		2a DATE OF DEATH		2b HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		P M	
Lyle Kenneth FABrick		JUNE 8 1986		1 P	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7 BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	Aug. 25, 1908	77 YRS	Harford MD.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
No. Dakota	U.S.A.				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY		
Harford	Harford Memorial Hospital	Carpenter			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE	
Harford	Harford	Aberdeen	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	448 Paradise Rd 21001	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME				
John William Fabrick	Daisy Kirchner				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS		
NO	N/A	Estelle M. Fabrick	21001		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Distress</u>		about 6 min
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Progressive Chronic Renal Failure</u>		
DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Advanced Carcinoma of Prostate with Metastases</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	19c AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	P.M. 19	N/A	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION (CITY OR TOWN, COUNTY, STATE)	
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 6-8 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b SIGNATURE	DEGREE	22c DATE SIGNED	
M. J. A. Z. A. T. N. J.		6/8/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS		
LAZARUS, MANUEL	PO Box 575 8 Law St 21001		

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (CITY OR TOWN, COUNTY, STATE)
Burial	June 12, 1986	Angel Hill Cemetery	Harford, MD
24 FUNERAL DIRECTOR NAME	24b ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Tarring Funeral Home, P.A.,	Aberdeen, MD, 21001-3399	JUN 12 1986	John Davidson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as seen, any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

74

00-09051

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 86 17487		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Glenn A Fankhauser										2a. DATE KNOWN OF DEATH MONTH DAY YEAR XX 6 6 19 86		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 10 65	6. AGE (IN YEARS) (LAST BIRTHDAY) 21 YRS.	IF UNDER 1 YR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 19 86		2d. HOUR M 1:45A				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. J.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.						
10. CITY OR TOWN OF DEATH Edgewood Area		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Interstate 95 (120 mile)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Sales				
13a. STATE N. J.		13b. COUNTY Mercer		13c. CITY OR TOWN Hamilton Sq.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7 Capri Lane 99999 08690				
14. FATHER'S NAME FIRST MIDDLE LAST David A. Fankhauser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Ann Wolff								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 156-62-4452		17. INFORMANT 08690 David A. Fankhauser Hamilton Sq, NJ								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thermal injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:08AM 6/6 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver/auto/fixed object/auto fire								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 120 mile=I-95, Harford County, Maryland								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED June 6, 86				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-9-86		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. MD						
24. FUNERAL DIRECTOR NAME ADDRESS Cremation Society, of MD, Baltimore, MD				25a. DATE REC'D. BY REGISTRAR JUN 10 1986		25b. REGISTRAR'S SIGNATURE John [Signature]						

DMHM - 17
(VR A15 ME (5))

00-08383

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 4 8 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John F. Flynn, Jr.			2a. DATE OF DEATH MONTH DAY YEAR June 2, 1986		2b. HOUR P. 5:40 M.		
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1941		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 44 YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2105 Hackney Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dairy Mgr.		12b. KIND OF BUSINESS OR INDUSTRY A. & P.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Fallston	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 2105 Hackney Court 21047			
14 FATHER'S NAME FIRST MIDDLE LAST John F. Flynn Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Linhart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-40-9938		17 INFORMANT ADDRESS Charlotte Flynn (wife) same address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) CNS (central brain) metastases DUE TO, OR AS A CONSEQUENCE OF (c) Malignant melanoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Metastatic melanoma to liver, pancreas, spleen							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 24, 1986 to May 12, 1986 , that (I) (we) lost saw the deceased alive on May 12, 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hussain		22e. ADDRESS University Hosp. 9th Flr. S. Clinic					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/86		23c. NAME OF CEMETERY OR CREMATORY Highview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Md.	
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 4 1986			
24. FUNERAL DIRECTOR ADDRESS 9705 Belair Rd., Balto. Md. 21236							

BP



RECEIVED
JAN 14 1964
U.S. DEPT. OF JUSTICE

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00-08797

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17489

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DORA ELIZABETH GELLERMAN			2a. DATE OF DEATH MONTH DAY YEAR 6 8 86			2b. HOUR 12 25 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 17 04		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD	
10. CITY OR TOWN OF DEATH BEL AIR		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL AIR CARVALS CENT CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hamemaker	
13a. STATE Maryland		13b. COUNTY BALTIMORE		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Weaver C. Griggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Roberts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-44-2656		17. INFORMANT ADDRESS Patricia G. Kroeger 2617 Claret Dr. 21047			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD. CVA. Renal failure.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-2-85	
DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent U.T.I.			6-8-86	
DUE TO, OR AS A CONSEQUENCE OF (c)				

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-2-1985 to 6-8-1986, that (I) (we) last saw the deceased alive on 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. PAREKH				DEGREE MD.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. PAREKH MD.				22e. ADDRESS 1908 HARFORD RD. FALLSTON MD.			

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/11/86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR JUN 9 1986		25b. REGISTRAR'S SIGNATURE Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



LIBRARY COLLECTION

MANA

JUN 9 1968

00-10382

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17490
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GIBSON		FIRST Doris MIDDLE M LAST Gibson		2a. DATE OF DEATH MONTH 6 DAY 21 YEAR 86		2b. HOUR 8:00 AM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH Aug. DAY 20 YEAR 1921		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Harriman, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE Henry LAST Mahan		15. MOTHER'S MAIDEN NAME FIRST Edith MIDDLE -- LAST Kline		13e. STREET ADDRESS / ZIP CODE 2906 Kathleen Drive 21050			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 140-14-9055		17. INFORMANT Forest Hill, Md. 21050			
16c. WILLIAM B. GIBSON, 2906 KATHLEEN DRIVE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest / Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Auto M5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF Severe CMO (c) --							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 YEAR 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 6/18/86 CITY OR TOWN Pa. COUNTY Pa. STATE Pa.			
22a. I certify that (I) (this hospital) attended the deceased from 6/18/86 to 6/21/86 , that (I) (we) last saw the deceased alive on 6/21/86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE U. MAIR MD		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) U. MAIR MD		22e. ADDRESS 2112 Bel Air Road Fallston, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 24, 1986		23c. NAME OF CEMETERY OR CREMATORY R.A. Ferris Crematory		23d. LOCATION CITY OR TOWN W. Chester COUNTY Pa. STATE Pa.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon, Md. 21009		25a. DATE RECEIVED BY REGISTRAR JUN 24 1986		25b. REGISTRAR'S SIGNATURE James Henderson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 (showing injury, or other traumatic event), the medical examiner will be notified at once.

BP

100-10000



100-10000

100-10000

00-10722

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17491

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
WILLIAM A. GRAFF			6/25/86			0306A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR			
Male		White		April 30, 1917		69 YRS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
PA		USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		Fallston General Hospital		Electrician		Electrical					
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		13d. INSIDE CITY LIMITS?					
Florida		Kissimmee		2100 Pleasant Hill Rd. 32741		YES <input type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Peter Graff			Lois Cable								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			WW II			192 07 0584			Walker Funeral Home, PA		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Acute Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Coronary Artery Disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> , to <u>6/25</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6/25</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)											
22a. SIGNATURE						DEGREE			22c. DATE SIGNED		
<u>George L. Davis M.D.</u>											
22b. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
<u>George L. Davis M.D.</u>						<u>Fallston General Hospital, Fallston, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Removal-Burial			6/28/86		Greenwood Mem. Pk.			CITY OR TOWN COUNTY STATE			
								Lower Burrell, PA			
24. FUNERAL DIRECTOR						25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Henry W. Jenkins & Sons Co.						JUN 27 1986			<u>John Davidson</u>		
NAME ADDRESS											
4905 York Road Balto., MD 21212											

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

0-1565

100 Pleasant Hill Rd. 30241
Electrical
Orbis
Yonkers, N.Y.
10461

100 Pleasant Hill Rd. 30241
Electrical
Orbis
Yonkers, N.Y.
10461

100 Pleasant Hill Rd. 30241
Electrical
Orbis
Yonkers, N.Y.
10461

00-10545

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17492

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JUNIOUS GRAY			2a. DATE OF DEATH MONTH DAY YEAR 6-19-86			2b. HOUR 2:40 PM				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 9 97		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD				
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY civil service		
13a. STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1429 Perrywood Dr. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST not known					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not known					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-4793			17. INFORMANT ADDRESS Jane L. Grey 1429 Perrywood Dr. Aberdeen, Md.				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) End stage CVD DUE TO, OR AS A CONSEQUENCE OF (c) Severe ASKVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Anemia, Electrolyte Abnormalities

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/28, 1986, to 6/19, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M.D.				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.S. NAIR M.D.	
22e. ADDRESS 2112 Bel Air Road - Fallston MD 21047				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6-28-86		23c. NAME OF CEMETERY OR CREMATORY Tabernacle Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston Md. Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arnold Beard 353 Fountain St. Havre de Grace Md.				25a. DATE REC'D. BY REGISTRAR JUN 25 1986		25b. REGISTRAR'S SIGNATURE	

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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• T (GUTHRIE, 1981)

11 (a) 500

00-10385

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

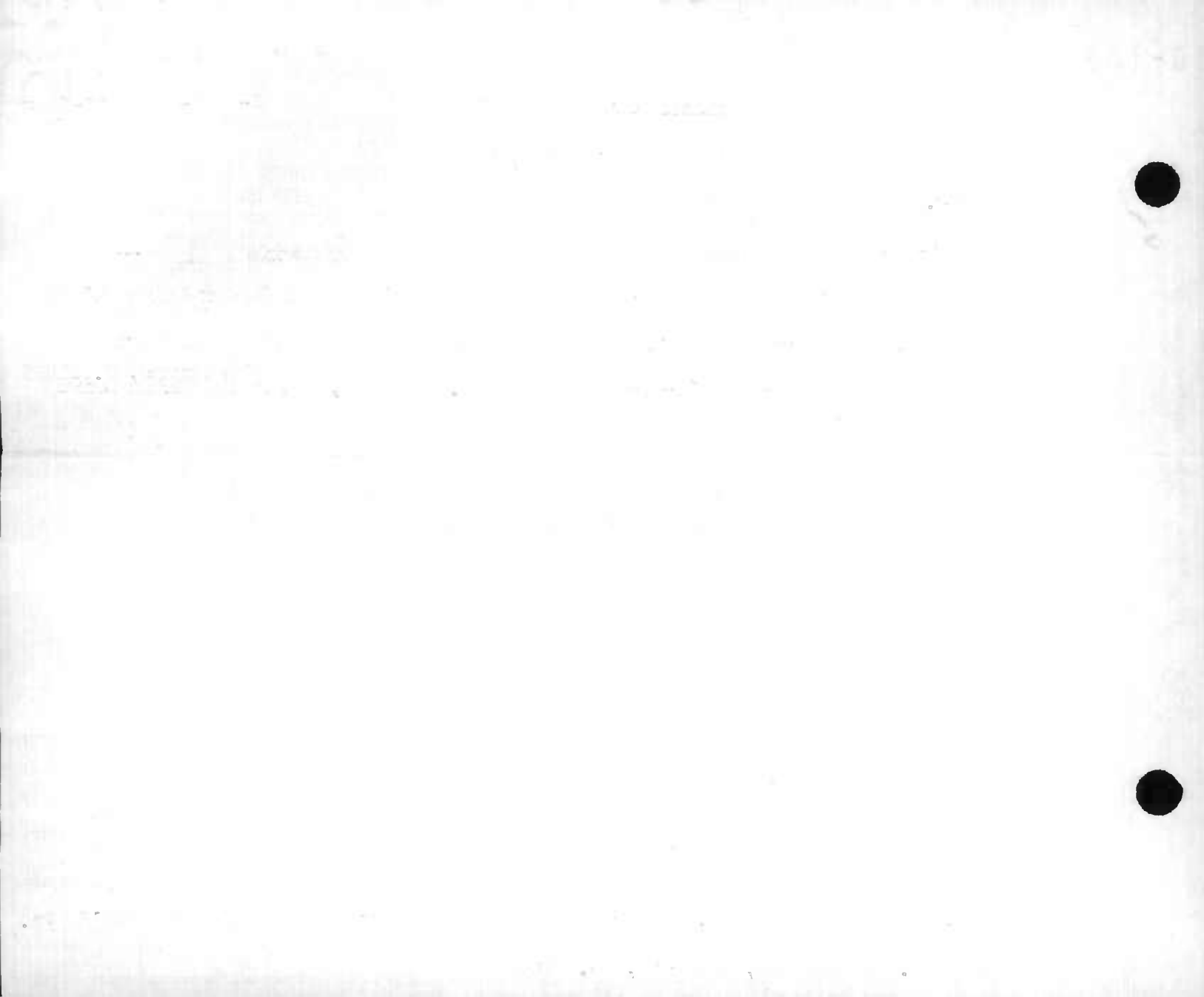
86

REG. NO.

17493

1. DECEASED NAME (TYPE OR PRINT) IVA GROOM RUTH GROOM		2a. DATE OF DEATH MONTH DAY YEAR 6- 22- 86		2b. HOUR 11-42am	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1892	
6. AGE (IN YEARS LAST BIRTHDAY) 94		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		8. CITIZEN OF WHAT COUNTRY? USA	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		10. CITY OR TOWN OF DEATH HAVRE-DE- GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --		13. STREET ADDRESS / ZIP CODE 726 Towne Center Drive 21085	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel -- Turner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Margaret Kephart		16. SOCIAL SECURITY NO. 215-22-5924	
17. INFORMANT ADDRESS Betty J. Hamilton, 726 Towne Center Drive Joppatowne, Md. 21085		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2-4 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 309 St. Union Ave. Havre de Grace	
22a. I certify that (I) (this hospital) attended the deceased from 2-4 19 86 , to 6-22 19 86 , that (I) (we) last saw the deceased alive on 6-17 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard K. McComas III		DEGREE		22c. DATE SIGNED 6-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard K. McComas III, M.D.		22e. ADDRESS 309 St. Union Ave. Havre de Grace		23a. DATE RECEIVED BY REGISTRAR JUN 24 1986	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Fruit Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Jordon Township Clearfield Pa.		23e. NAME OF FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009		23f. DATE RECEIVED BY REGISTRAR JUN 24 1986	

BP



00-10384

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 4 9 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MOLLIE MIDDLE MAE LAST HALL		2a. DATE OF DEATH MONTH DAY YEAR June 21 1986		2b. HOUR 5:50 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 1, 1924	
6. AGE (IN YEARS LAST BIRTHDAY) 62		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Toll Collector	
12b. KIND OF BUSINESS OR INDUSTRY JFK Highway		13a. STATE Md.			
13b. COUNTY Harford		13c. CITY OR TOWN Joppa		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Robert Pierce		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche — Baldwin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-20-7171		17. INFORMANT ADDRESS 21085 George S. Hall, 1507 Clayton Road, Joppa, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast with metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 6-14, 1986, to 6-21, 1986, that (I) (we) last saw the deceased alive on 6-21, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE SANG W. KIM		DEGREE M.D.		22c. DATE SIGNED June 21, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG W. KIM		22e. ADDRESS 308 S. Union Ave. Havre de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 24, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air Harford Md.	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009			
25a. DATE REG'D. BY REGISTRAR JUN 24 1986		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified.

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00-11020

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 4 9 5
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Annie C. Huber			2a. DATE OF DEATH MONTH DAY YEAR 6 20 86		2b. HOUR 8:20 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD	
10. CITY OR TOWN OF DEATH Street		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1355 Quaker Church Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Street	
14. FATHER'S NAME FIRST MIDDLE LAST John Schnepf				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Patton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-12-8642		17. INFORMANT Mr. Otto A. Huber,		ADDRESS Street, Md. 21154 1355 Quaker Church Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic ca of esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:20 P.M. 6 20 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from 12/11/85 to 6/20/86, that (I) (we) last saw the deceased alive on 12/30/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Richard M. Silverstein</u> M.D.				22c. DATE SIGNED 4/20/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Silverstein	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-23-1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassahn Funeral Home				ADDRESS 11750 Bel Air Rd. KINGSVILLE, MD. 21087		25a. DATE REC'D. BY REGISTRAR JUN 25 1986	
25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall							

MEDICAL CERTIFICATION

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP
DHMH - 16 50M 4/83
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 17496
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles C Jackson Sr		2a. DATE OF DEATH MONTH DAY YEAR June 19 1986		2b. HOUR 12:46 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR August 27 1911	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) P. Mutual Clerk		12b. KIND OF BUSINESS OR INDUSTRY RACING			
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14. FATHER'S NAME FIRST MIDDLE LAST WARREN JACKSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTIE HEATH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 09 8876		17. INFORMANT ADDRESS Louise E. Jackson, 209 Hollingsworth Manor, Elkton, Md. 21921	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute coronary insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Common iliac arterial thrombo-embolism PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Metabolic acidosis, combined.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 6 - 19 19 86 , to 6 - 19 19 86 , that (I) (we) last saw the deceased alive on 6 - 19 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22a. SIGNATURE [Signature]		DEGREE		22b. DATE SIGNED 6/19/86	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) AMAKOWS M. D.		22e. ADDRESS 389 So. Union Ave 1st fl. Rd			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/23/86		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.		24. FUNERAL DIRECTOR NAME Joseph E. Hicks		25a. DATE REC'D. BY REGISTRAR JUN 26 1986	
24. FUNERAL DIRECTOR ADDRESS Hicks Home for Funerals, Elkton, Md.		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

01072

Charles O. Johnson & Co. Inc. 100 N. 1st St. St. Louis, Mo.

Dear Sirs:
We are pleased to hear from you and
thank you for your letter of the 10th inst.
and for the information you have given us.
We are sorry that we cannot give you
the information you desire at this time.
We are sorry that we cannot give you
the information you desire at this time.

Very truly yours,
Charles O. Johnson & Co. Inc.
St. Louis, Mo.

Yours very truly,
Charles O. Johnson & Co. Inc.
St. Louis, Mo.

00-08787

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Charles		MIDDLE L.		LAST Johnston		Sr.		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 7 19 86		2b. HOUR 2:24 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1903		6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 7 19 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Belair Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) M.T.A. Bus Driver				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1704 Summit Avenue 21237					
14. FATHER'S NAME FIRST MIDDLE LAST Jermiah Johnston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally O'Neill									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-2828		17. INFORMANT ADDRESS Mr. Charles L. Johnston Jr. 6209 Eastern Pkway 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Septicemia / urosepsis DUE TO, OR AS A CONSEQUENCE OF (c) 1-2 weeks												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). ① Chronic idling of Foley catheter													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE David McClure				TITLE (SPECIFY) MD				MEDICAL EXAMINER				DATE SIGNED 6/7/86	
EXAMINER'S NAME (TYPE OR PRINT) DAVID McClure MD				ADDRESS 1131 Bel Air Rd				Bel Air, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/12/86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc.						ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 9 1986		25b. REGISTRAR'S SIGNATURE June Davidson			

22.

Nov. 17, 1907

Harford

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M.T.A. Bus Driver

Pointe Neuvaine House

Bel Air

1704 Spruce Avenue 21277

Woodsdale

Baltimore

Ed.

21277

21277

Johnston

Johnston

Box 21277

Mr. Charles L. Johnston Jr. 6209 Eastern

no

Bel Air

Pointe Neuvaine House

Bel Air

Isaacson & Sons Inc. Baltimore, Maryland

00-10442

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 4 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Walter Bernard Jourdan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6/16/86</i>			2b. HOUR <i>3:00am</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 6 1917</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Darlington</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1415 Stafford Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Grain</i>	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>1415 Stafford Road/21154</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Darlington</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Bernard G.S. Jourdan</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sara Jane Pyle</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-14-8990</i>		17. INFORMANT ADDRESS <i>Darlington, MD 21154</i> <i>Blanche S. Jourdan 1415 Stafford Road</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Metastatic Prostatic Carcinoma</i>			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>7/11 1986</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>5601 Loch Raven Blvd Darlington Harford MD</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/11 1986</i> to <i>6/16 1986</i> , that (I) (we) last saw the deceased alive on <i>4/27 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b. SIGNATURE <i>Davis M Hahn</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Davis M Hahn</i>		22e. ADDRESS <i>5601 Loch Raven Blvd</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6/18/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Darlington Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Darlington Harford MD</i>	
24. FUNERAL DIRECTOR NAME <i>John Harkins 600 Main Street Delta, PA 17314</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 23 1986</i>			
				25b. REGISTRAR'S SIGNATURE <i>John Harkins</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certification of death. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or disposition. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP

Figure 1. Schematic representation of the experimental design.

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Items 18 & 22a Film G617 7/25/86 ja
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17499

0-09636

1. DECEASED NAME (TYPE OR PRINT) HENRY JAMES LAUBACH		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 15 19 86		2b. HOUR AM PM 7:25 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 25, 1957	6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Christian Laubach, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joyce Ramonia Owensby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-68-2639		17. INFORMANT ADDRESS Joyce R. Laubach, 2911 Creswell Road, Bel Air, Md. 21014

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 4279 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE Margarita A. Korell M.D. Assistant MEDICAL EXAMINER		TITLE (SPECIFY) Assistant
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		DATE SIGNED 6-16-86

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE June 19, 1986	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.
24. FUNERAL DIRECTOR NAME ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR JUN 23 1986	
		25b. REGISTRAR'S SIGNATURE Julia Anderson-Pudner	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00387-0

DO NOT WRITE

DAVIDSON



JUN 22 1988

0-10659

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17500

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Dorothy		FIRST ##		MIDDLE ##		LAST LEONARD		2a. DATE OF DEATH (JUNE 20, 1986) JUNE 20 1986		MONTH JUNE 20 1986		DAY 4 25		YEAR 4 P.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 29, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 2 YRS HOURS MIN.		9. BALTIMORE CITY OR COUNTY OF DEATH (Harford County)		10. HARFORD MD.					
7a. BIRTHPLACE (COUNTRY) Darlington Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH (Harford County)		10. HARFORD MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY clothing store					
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Joppa (21085)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 725 TOWNE Center Dr. 21085		14. FATHER'S NAME FIRST MIDDLE LAST William H. MAIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ELLEN WALLACE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-34-6537		17. INFORMANT (NAME) 679-6060 ADDRESS 679-5292 752 TOWNE CENTER DRIVE Joppa, Maryland 21085	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Hematoma DUE TO, OR AS A CONSEQUENCE OF (b) AS COP. DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 - 9 19 86				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 6 - 9 19 86 to 6 - 20 19 86 that (I) (we) last saw the deceased alive on 6 - 20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.																			
22b. SIGNATURE J. F. Lee				22c. ADDRESS Cenou Med. Clinic				22d. DATE SIGNED 6/20/86											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE JUNE 23, 1986				23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Darlington, Harford Co, Maryland 21034							
24. FUNERAL DIRECTOR Joseph William Fester Imperial Funeral				25a. DATE REC'D. BY REGISTRAR JUN 24 1986				25b. REGISTRAR'S SIGNATURE John F. ...											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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00-09277

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17501

1. DECEASED NAME (TYPE OR PRINT)			FIRST VIOLA			MIDDLE GLADYS			LAST MARCHANT			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 9 1986			2b. HOUR M noon				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 05 07		6. AGE (IN YEARS) (LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 9 1986			2d. HOUR M 12:00				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.							
10. CITY OR TOWN OF DEATH Joppa				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 580 Trimble Road						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper				12b. KIND OF BUSINESS OR INDUSTRY Construction					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland				13b. COUNTY Harford				13c. CITY OR TOWN Joppa 21085				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 580 Trimble Rd 21085			
14. FATHER'S NAME FIRST MIDDLE LAST Harry -- Corless									15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma V. (unknown)										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --				17. INFORMANT ADDRESS 21085 Anna Vacek, 580 Trimble Road, Joppa, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-9 1986						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted gunshot wound							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 580 Trimble Rod, Joppa Harford Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																			
ACTUAL SIGNATURE DATE SIGNED 6/10/86																			
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St., Baltimore 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE June 12, 1986						23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery							
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Md.						25a. DATE REC'D. BY REGISTRAR JUN 12 1986						25b. REGISTRAR'S SIGNATURE J. C. Davidson							
24. FUNERAL DIRECTOR NAME Howard K. McComas III						ADDRESS 1317 Cokesbury Rd. Abingdon, Md. 21009													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM, PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17502
REG. NO.

1- FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Milton Mathiowdis			6/7/86			4 ^{PM}			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 5 29		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (COUNTRY) STATE OR FOREIGN Ohio		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.			
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 305 Umbarger Dr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public School System Educator		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Harford		13d. CITY OR TOWN Bel Air		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 305 Umbarger Dr. 21014	
14 FATHER'S NAME FIRST MIDDLE LAST James Mathiowdis		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Urania Gowla-Takos							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Navy-Korea 214-26-2135		17 INFORMANT (Wife) ADDRESS Dolores S. Mathiowdis Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA OF LEFT LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 1/20/86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. OF LEFT LUNG		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN, COUNTY, STATE)					
22a. I certify that (1) this hospital attended the deceased from 1/7/86 to 6/86, that (2) (we) last saw the deceased alive on 5/22/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE H. McWilliams, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/9/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. McWilliams, M.D.		22e. ADDRESS FACULTY GEN'L. HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/10/86		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Church		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Pylesville Harford Maryland			
24. FUNERAL DIRECTOR NAME Fleming Funeral Service		24b. ADDRESS 21018 Benson, Md.		25a. DATE REC'D. BY REGISTRAR JUN 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director for 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) CARRIE Beatrice DYE Mergler					2a. DATE OF DEATH JUNE 26, 1986		2b. HOUR 11:50 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MAY 4, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 610 Franklin St 21078	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM M. DYE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE J. HORNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-54-8277		17. INFORMANT ADDRESS VIVIAN M. BURNS 118 SPRING LAKE WAY, HAVRE de GRACE 21078			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and atherosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Heart Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>6-26</u> , 19 <u>86</u> , to <u>6-26</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>6-26/86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bryan T. Yeo M.D.				22c. DATE SIGNED 6/27/86				22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T. YEO, MD	
22e. ADDRESS Havre de Grace, Maryland 21078				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 30 JUNE 86		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078				25a. DATE REC'D. BY REGISTRAR JUN 30 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17504

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Leana Erika Mitchell			2a. DATE OF DEATH MONTH DAY YEAR June 24, 1986		2b. HOUR 3:00am				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 28, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 65 Ray Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 65 Ray Avenue/21001	
14. FATHER'S NAME FIRST MIDDLE LAST Wilhelm Protzel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frieda Morrell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA		17. INFORMANT ADDRESS George W. Mitchell, 65 Ray Ave., Aberdeen, MD 21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MEASTATIC MESOTHELIOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19</u> 19 <u>86</u> to <u>6/24</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>6/19</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. Eck</u>				DEGREE MD				22c. DATE SIGNED 6/24/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CURCHES R. ECK JR				22e. ADDRESS 223 W. BELAIR AVE ABERDEEN					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun. 27, 1986		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Harford, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR JUN 30 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION

229

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE
HONOLULU, HAWAII

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FROM: [illegible]
SUBJECT: [illegible]
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00-08889

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17505

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) SARA E. MUSSER		JUNE 4, 1986		1:23 AM	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH APRIL 12, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY, MD.	
10. CITY OR TOWN OF DEATH HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BREVIN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. CITY OR TOWN CECIL	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 37 BARKSDALE CT. 21921	
14. FATHER'S NAME John J. Williams		15. MOTHER'S MAIDEN NAME Ida May Buckingham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NA	16b. SOCIAL SECURITY NO. 221-07-9088	17. INFORMANT Alfred E. Musser Jr. 37 Barksdale Court			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION - DUE TO, OR AS A CONSEQUENCE OF CARDIO RESPIRATORY FAILURE (b) (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a RENAL INSUFFICIENCY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 HRS.
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-9-86 to 6-3-86, that (I) (we) last saw the deceased alive on 6-3-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kamrupin Mithani		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6.4.86.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAMRUPIN MITHANI		22e. ADDRESS 1315 UNION AVE. HAVRE DE GRACE MD 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 6/6/86	23c. NAME OF CEMETERY OR CREMATORY Newark Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Newark, New Castle, Del.	
24. FUNERAL DIRECTOR F. J. Davis		25a. DATE REC'D. BY REGISTRAR JUN 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 5 0 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertrude V Myers			2a. DATE OF DEATH MONTH DAY YEAR 6 4 86			2b. HOUR 8⁵⁰ AM			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 4 26 07		6. AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Univ of Akron		12b. KIND OF BUSINESS OR INDUSTRY Food Serv.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? Maryland Harford Bel Air YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13. STREET ADDRESS / ZIP CODE 2009 Cypress Dr. 21014				
14. FATHER'S NAME 14a. FIRST 14b. MIDDLE 14c. LAST William Switter					15. MOTHER'S MAIDEN NAME 15a. FIRST 15b. MIDDLE 15c. LAST Emilia Neiser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 269-40-5672		17. INFORMANT (NAME) Darla Bell		17. ADDRESS Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multisystem Organ Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF: (c) Toxicemic Bowel Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George Laws M.D.						DEGREE MD.		22c. DATE SIGNED 6/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Laws M.D.						22e. ADDRESS Fallston General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/7/86		23c. NAME OF CEMETERY OR CREMATORY Glendale Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Akron Summit Ohio		
24. FUNERAL DIRECTOR NAME ADDRESS Fleming Funeral Service Benson, Md.						25a. DATE REC'D. BY REGISTRAR JUN 5 1986			
25b. REGISTRAR'S SIGNATURE [Signature]									

BP

00-095831

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17507

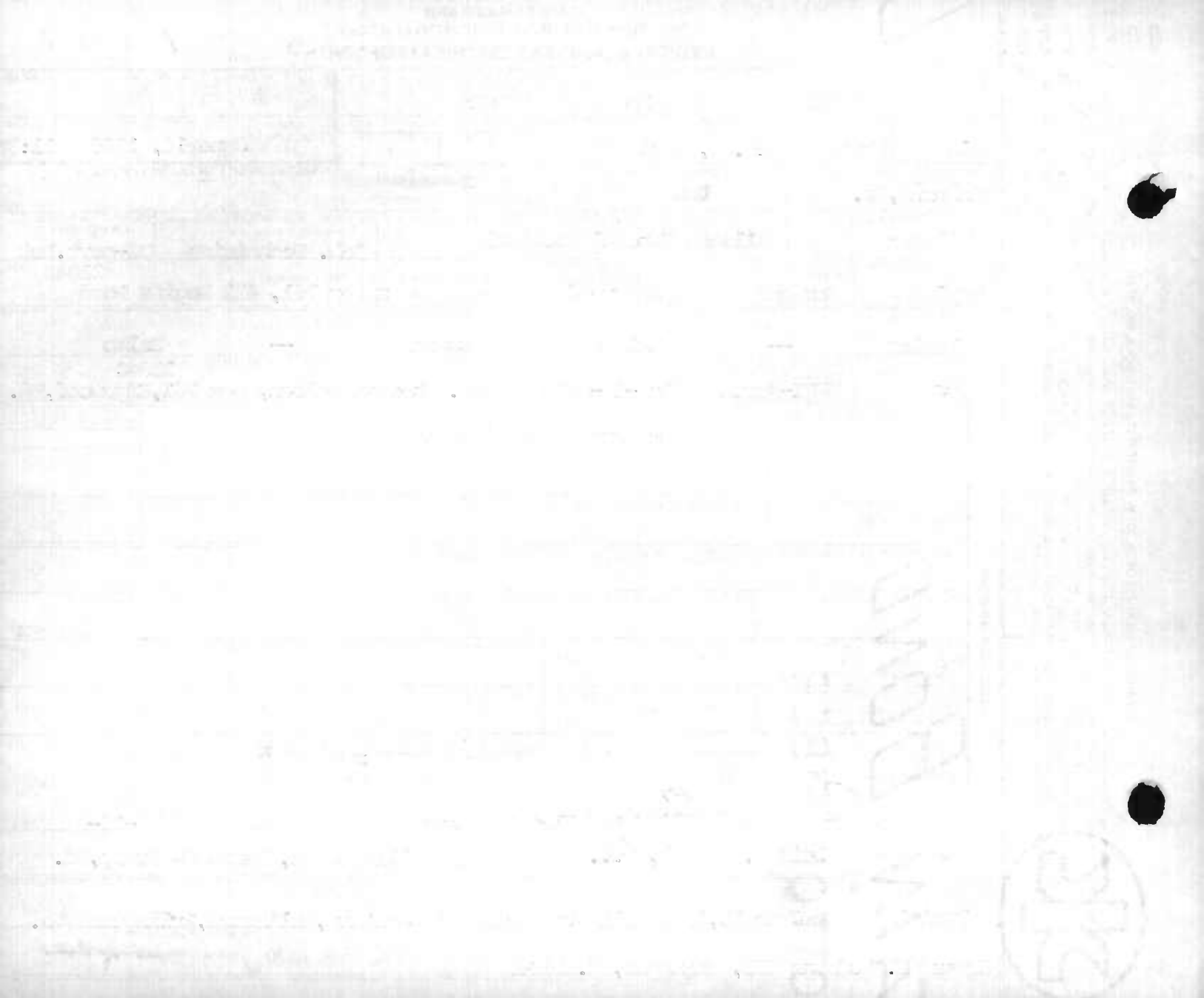
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
RALPH		DONALD		NELSON								19							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		White		Feb. 4, 1922		64 YRS.						June 14, 1986						11:36	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Winburne, Pa.		USA				<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Fallston		Fallston General Hospital		Lab. Technician		US-govt. Ret													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland		Harford		Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 761, 422 Regina Road										21040	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Charles		Lydia																Balko	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		WWII-Korea		184-18-6855		Mrs. Theresa Nelson, Box 761, Edgewood, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Coronary Heart Disease		DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
								(b)											
								(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion											
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		6-14-86													
EXAMINER'S NAME (TYPE OR PRINT)		Luis E. Renjel, M.D.		ADDRESS		464 Alliance St, Havre de Grace, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Burial		June 18, 1986		Arlington National Cemetery, Arlington, Va.		Arlington, Va.													
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Howard K. McComas III, Abingdon, Md.		21009		JUN 17 1986		June Davidson-Rendall													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



00-09079

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITHIN THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17508	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SOK NAK NMN PIN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6 8 19 86	
3. SEX F	4. RACE ORIENTAL	5. DATE OF BIRTH MONTH DAY YEAR 6 3 75		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 11	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 8 19 86	2d. HOUR 3a	2e. HOUR 3a	2f. HOUR 3a	2g. HOUR 3a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CAMBODIA		7b. CITIZEN OF WHAT COUNTRY? CAMBODIA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. BALTIMORE CITY OR COUNTY OF DEATH HARFORD					
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY ELEM. SCHOOL			
14. FATHER'S NAME FIRST MIDDLE LAST SEVY Pres										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PUN NHIV	
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 619 N. Adams St. 21078			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 900-71-3634		17. INFORMANT ADDRESS Hospital records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Car accident DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Luis E Rengel				TITLE (SPECIFY) M.D. Deput				DATE SIGNED 6-8-86			
EXAMINER'S NAME (TYPE OR PRINT) Luis E Rengel				ADDRESS 464 allamore st Harf							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12 JUNE 86		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE HAVRE de GRACE, HARFORD CO., MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, Havre de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR JUN 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson			

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1955 AUG

00-08948

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8617509
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MADDALENA		FIRST PLUDE		LAST		2a DATE OF DEATH MONTH DAY YEAR 6 7 86		2b HOUR 105 A	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 5 6 27		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10 CITY OR TOWN OF DEATH FALLSTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Own Home	
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Pylesville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4038 Grandview Drive/21132	
14 FATHER'S NAME FIRST MIDDLE LAST Amedeo Marchianne				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 4541-32-9872		17 INFORMANT ADDRESS Harold E. Plude, 4038 Grandview Drive					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Severe CAD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ascvd DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 6 19 87 to 86 , that (I) (we) last saw the deceased alive on May 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) the body after death .									
22b SIGNATURE M. D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 6/7/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. NAIR M.D.				22e ADDRESS 2112 Bel Air Road, Fallis M. Plude					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 6/11/86		23c NAME OF CEMETERY OR CREMATORY Canarsie Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brooklyn Kings NY			
24 FUNERAL DIRECTOR NAME ADDRESS John H. Harkins, 600 Main Street, Delta, PA						25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full. The list is as follows:

Mr. J. H. Smith	1234 Main St.	Springfield, Mass.
Mr. W. E. Jones	5678 Elm St.	Springfield, Mass.
Mr. R. L. Brown	9012 Oak St.	Springfield, Mass.
Mr. T. M. Green	3456 Pine St.	Springfield, Mass.
Mr. S. K. White	7890 Cedar St.	Springfield, Mass.
Mr. L. P. Black	2345 Birch St.	Springfield, Mass.
Mr. D. N. Gray	6789 Walnut St.	Springfield, Mass.
Mr. C. O. Hall	1011 Chestnut St.	Springfield, Mass.
Mr. F. G. Young	4321 Spruce St.	Springfield, Mass.
Mr. B. A. King	8765 Ash St.	Springfield, Mass.
Mr. H. I. Lee	2109 Hickory St.	Springfield, Mass.
Mr. J. M. Scott	6543 Willow St.	Springfield, Mass.
Mr. K. J. Adams	0987 Sycamore St.	Springfield, Mass.
Mr. N. H. Baker	5432 Dogwood St.	Springfield, Mass.
Mr. P. L. Carter	9876 Magnolia St.	Springfield, Mass.
Mr. Q. R. Evans	3210 Juniper St.	Springfield, Mass.
Mr. R. S. Foster	7654 Redwood St.	Springfield, Mass.
Mr. T. U. Gibson	1098 Cypress St.	Springfield, Mass.
Mr. V. W. Harris	5432 Fir St.	Springfield, Mass.
Mr. X. Y. Ingram	9876 Hemlock St.	Springfield, Mass.
Mr. Z. A. Jackson	3210 Larch St.	Springfield, Mass.
Mr. A. B. Keller	7654 Locust St.	Springfield, Mass.
Mr. C. D. Lewis	1098 Maple St.	Springfield, Mass.
Mr. E. F. Miller	5432 Mulberry St.	Springfield, Mass.
Mr. G. H. Nelson	9876 Peach St.	Springfield, Mass.
Mr. I. J. Oliver	3210 Plum St.	Springfield, Mass.
Mr. K. L. Parker	7654 Rose St.	Springfield, Mass.
Mr. M. N. Quinn	1098 Strawberry St.	Springfield, Mass.
Mr. O. P. Reed	5432 Tangerine St.	Springfield, Mass.
Mr. Q. R. Smith	9876 Watermelon St.	Springfield, Mass.
Mr. S. T. Thomas	3210 Zucchini St.	Springfield, Mass.

2. The second part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full. The list is as follows:

Mr. J. H. Smith	1234 Main St.	Springfield, Mass.
Mr. W. E. Jones	5678 Elm St.	Springfield, Mass.
Mr. R. L. Brown	9012 Oak St.	Springfield, Mass.
Mr. T. M. Green	3456 Pine St.	Springfield, Mass.
Mr. S. K. White	7890 Cedar St.	Springfield, Mass.
Mr. L. P. Black	2345 Birch St.	Springfield, Mass.
Mr. D. N. Gray	6789 Walnut St.	Springfield, Mass.
Mr. C. O. Hall	1011 Chestnut St.	Springfield, Mass.
Mr. F. G. Young	4321 Spruce St.	Springfield, Mass.
Mr. B. A. King	8765 Ash St.	Springfield, Mass.
Mr. H. I. Lee	2109 Hickory St.	Springfield, Mass.
Mr. J. M. Scott	6543 Willow St.	Springfield, Mass.
Mr. K. J. Adams	0987 Sycamore St.	Springfield, Mass.
Mr. N. H. Baker	5432 Dogwood St.	Springfield, Mass.
Mr. P. L. Carter	9876 Magnolia St.	Springfield, Mass.
Mr. Q. R. Evans	3210 Juniper St.	Springfield, Mass.
Mr. R. S. Foster	7654 Redwood St.	Springfield, Mass.
Mr. T. U. Gibson	1098 Cypress St.	Springfield, Mass.
Mr. V. W. Harris	5432 Fir St.	Springfield, Mass.
Mr. X. Y. Ingram	9876 Hemlock St.	Springfield, Mass.
Mr. Z. A. Jackson	3210 Larch St.	Springfield, Mass.
Mr. A. B. Keller	7654 Locust St.	Springfield, Mass.
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Mr. G. H. Nelson	9876 Peach St.	Springfield, Mass.
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Mr. M. N. Quinn	1098 Strawberry St.	Springfield, Mass.
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Mr. Q. R. Smith	9876 Watermelon St.	Springfield, Mass.
Mr. S. T. Thomas	3210 Zucchini St.	Springfield, Mass.

3. The third part of the document is a list of the names and addresses of the persons who have been notified of the hearing. The names are listed in alphabetical order, and the addresses are given in full. The list is as follows:

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Mr. S. K. White	7890 Cedar St.	Springfield, Mass.
Mr. L. P. Black	2345 Birch St.	Springfield, Mass.
Mr. D. N. Gray	6789 Walnut St.	Springfield, Mass.
Mr. C. O. Hall	1011 Chestnut St.	Springfield, Mass.
Mr. F. G. Young	4321 Spruce St.	Springfield, Mass.
Mr. B. A. King	8765 Ash St.	Springfield, Mass.
Mr. H. I. Lee	2109 Hickory St.	Springfield, Mass.
Mr. J. M. Scott	6543 Willow St.	Springfield, Mass.
Mr. K. J. Adams	0987 Sycamore St.	Springfield, Mass.
Mr. N. H. Baker	5432 Dogwood St.	Springfield, Mass.
Mr. P. L. Carter	9876 Magnolia St.	Springfield, Mass.
Mr. Q. R. Evans	3210 Juniper St.	Springfield, Mass.
Mr. R. S. Foster	7654 Redwood St.	Springfield, Mass.
Mr. T. U. Gibson	1098 Cypress St.	Springfield, Mass.
Mr. V. W. Harris	5432 Fir St.	Springfield, Mass.
Mr. X. Y. Ingram	9876 Hemlock St.	Springfield, Mass.
Mr. Z. A. Jackson	3210 Larch St.	Springfield, Mass.
Mr. A. B. Keller	7654 Locust St.	Springfield, Mass.
Mr. C. D. Lewis	1098 Maple St.	Springfield, Mass.
Mr. E. F. Miller	5432 Mulberry St.	Springfield, Mass.
Mr. G. H. Nelson	9876 Peach St.	Springfield, Mass.
Mr. I. J. Oliver	3210 Plum St.	Springfield, Mass.
Mr. K. L. Parker	7654 Rose St.	Springfield, Mass.
Mr. M. N. Quinn	1098 Strawberry St.	Springfield, Mass.
Mr. O. P. Reed	5432 Tangerine St.	Springfield, Mass.
Mr. Q. R. Smith	9876 Watermelon St.	Springfield, Mass.
Mr. S. T. Thomas	3210 Zucchini St.	Springfield, Mass.

00-09556

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 5 1 0
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Benjamin Burdell Preston, Jr</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 12 1986</i>		2b. HOUR <i>2:45 P</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>August 16, 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i> YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i> MD		
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>	13c. CITY OR TOWN <i>Churchville</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin Burdell Preston, Sr.</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Beulah Welsh</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>212-14-0551</i>		17. INFORMANT ADDRESS <i>Susan P. Plesce, Same as Above</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>acute leukemia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>myelofibrosis</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>June 12</i> , 19 <i>86</i> to <i>June 12</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>June 12</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>B. J. Plunkett Jr</i> M.D.				22c. DATE SIGNED <i>June 13, 1986</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>6/15/86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Baker Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Aberdeen, Harford, Maryland</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>Tarring Funeral Home, PA. Aberdeen, MD. 21001-3399</i>		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>L. C. Knickerbocker</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JUN 16 1986



100% COTTON FIBER

WINTER

OVER

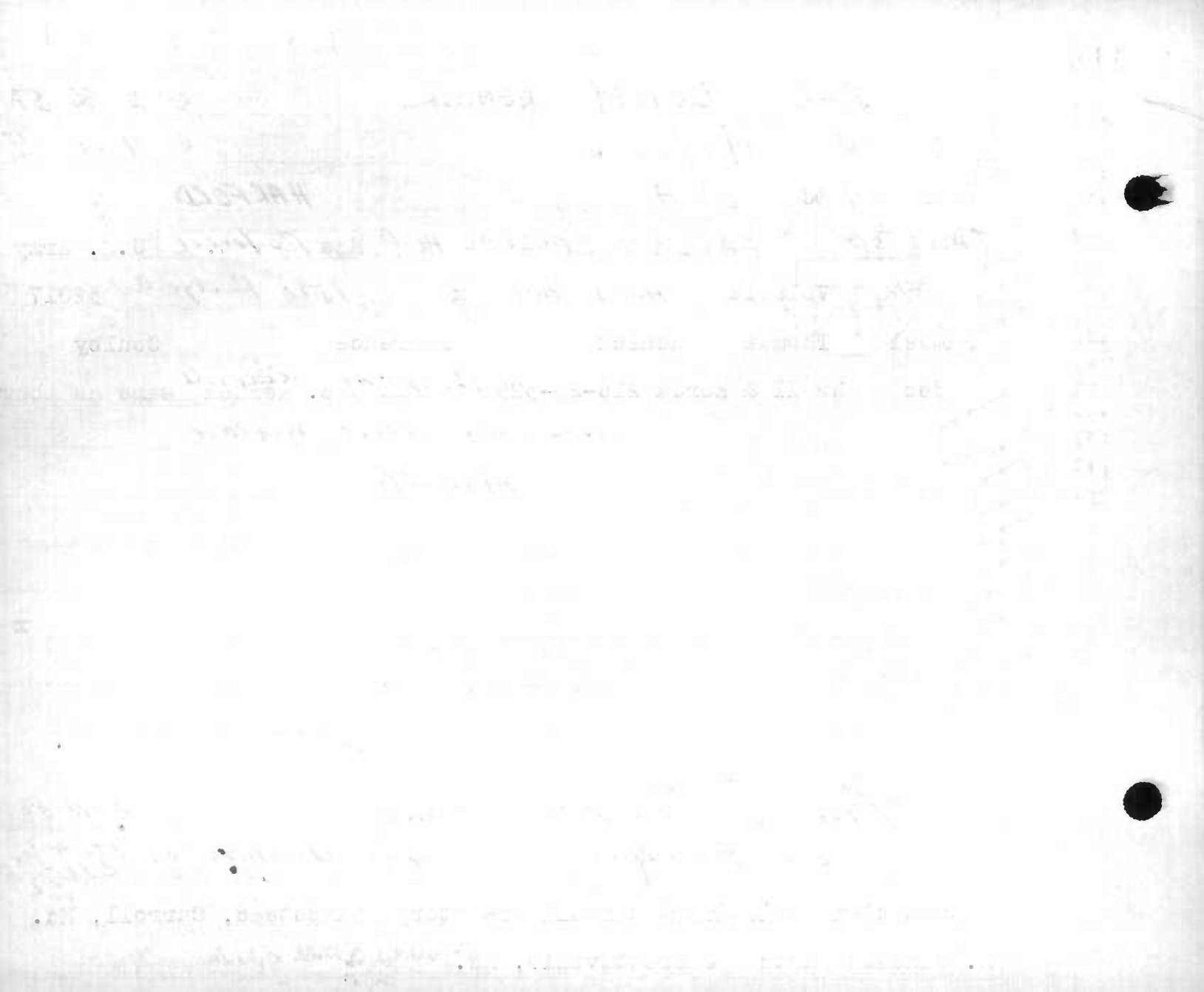


-09919

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										6		17511			
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN		MIDDLE COULBY		LAST RENICK		2a. DATE OF DEATH		KNOWN ESTIMATED		MONTH DAY YEAR		2b. HOUR MIN.	
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9/1/22		6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD									
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Master Sgt.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army									
13a. STATE F-la		13b. COUNTY Volusia		13c. CITY OR TOWN Holly Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1520 Ridge Rd							
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Thomas Renick		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Coulby													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II & Korea 216-20-3252		17. INFORMANT Patricia B. Renick		ADDRESS same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY HEART DISEASE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) ASCVD (c) DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Lew E Renick				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 6-11-86							
EXAMINER'S NAME (TYPE OR PRINT) Lew E Renick MD				ADDRESS 464 Alliance St											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 6/13/1986		23c. NAME OF CEMETERY OR CREMATORY Carroll Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Carroll, Md.					
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz				ADDRESS Jarrettsville, Md.				25a. DATE REC'D. BY REGISTRAR JUN 13 1986				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



00-08883

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 1 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE ROSE ROBINSON		2a. DATE OF DEATH MONTH DAY YEAR JUNE 5 1986		2b. HOUR 8:55 AM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR JULY 19, 1931	
6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MOTEL OWNER	
12b. KIND OF BUSINESS OR INDUSTRY —		13a. STATE MD.		13b. COUNTY Harford	
13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1400 S. Philadelphia Blvd 21001	
14. FATHER'S NAME FIRST MIDDLE LAST MIKE NICHOLS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL VANDERPOOLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS H.E. ROBINSON - SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR (APPROX)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22. I certify that (I) (this hospital) attended the deceased from June 5 , 19 86 , to June 5 , 19 86 , that (I) (we) last saw the deceased alive on June 5 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE B. J. Plunkett		DEGREE MD		22c. DATE SIGNED 6-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. J. Plunkett		22e. ADDRESS 517 S. Union Ave. Harre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUN. 7, 1986		23c. NAME OF CEMETERY OR CREMATORY SPESUTIA CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE PERRYMAN, HARFORD, MD		24. FUNERAL DIRECTOR NAME ADDRESS TARRING FUNERAL HOME, P.A., ABERDEEN, MD. 21001-3399			
25a. DATE REC'D. BY REGISTRAR JUN 9 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Harford			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

Handwritten notes and signatures, including a large 'E' and 'N' in the center.



00-09670

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

17513

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence Leon Rosier			2a. DATE OF DEATH MONTH DAY YEAR 6 8 86			2b. HOUR M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 5 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Joppa		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 Fern Drive Joppa Maryland				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed			12b. KIND OF BUSINESS OR INDUSTRY Tavern/Motel		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 105 Fern Drive Joppa Maryland 21085		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Rosier						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Rosier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 216-03-2666		17. INFORMANT ADDRESS Ronald David Rosier 4910 White Marsh Rd. 21237							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1979</u> to <u>June 8, 1986</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 10, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul Chang, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/9/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul Chang			22e. ADDRESS Good Samaritan Prof. Bldg. Suite 107								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-12-86		23c. NAME OF CEMETERY OR CREMATORY Holly Hills			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home			ADDRESS 1401 Belair Rd. BALTO. MD. 21238			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Julia Darden		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove coroner papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 showing injury, or other traumatic event, the medical examiner must be notified of such.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617514

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HARRY ROSS			2a. DATE OF DEATH MONTH DAY YEAR 6 30 86			2b. HOUR 12:20 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 22, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY STAGE DELI.	
13a. STATE MARYLAND		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3508 CAR SINWOOD DR. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM RABINOWITZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) WWI-ARMY 062-09-1466		17. INFORMANT MRS. HELEN ROSS 3508 CAR SINWOOD DR. ABERDEEN, MD 21001					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intoxication Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (or we did not) view the body after death.									
22b. SIGNATURE <i>Shliaberg</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SHLIABERG			22e. ADDRESS CITIZENS NURSING HOME - HAVRE DE GRACE, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JULY 2, 1986		23c. NAME OF CEMETERY OR CREMATORY HARFORD JEWISH CENTER		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JUL 3 - 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



00-08945

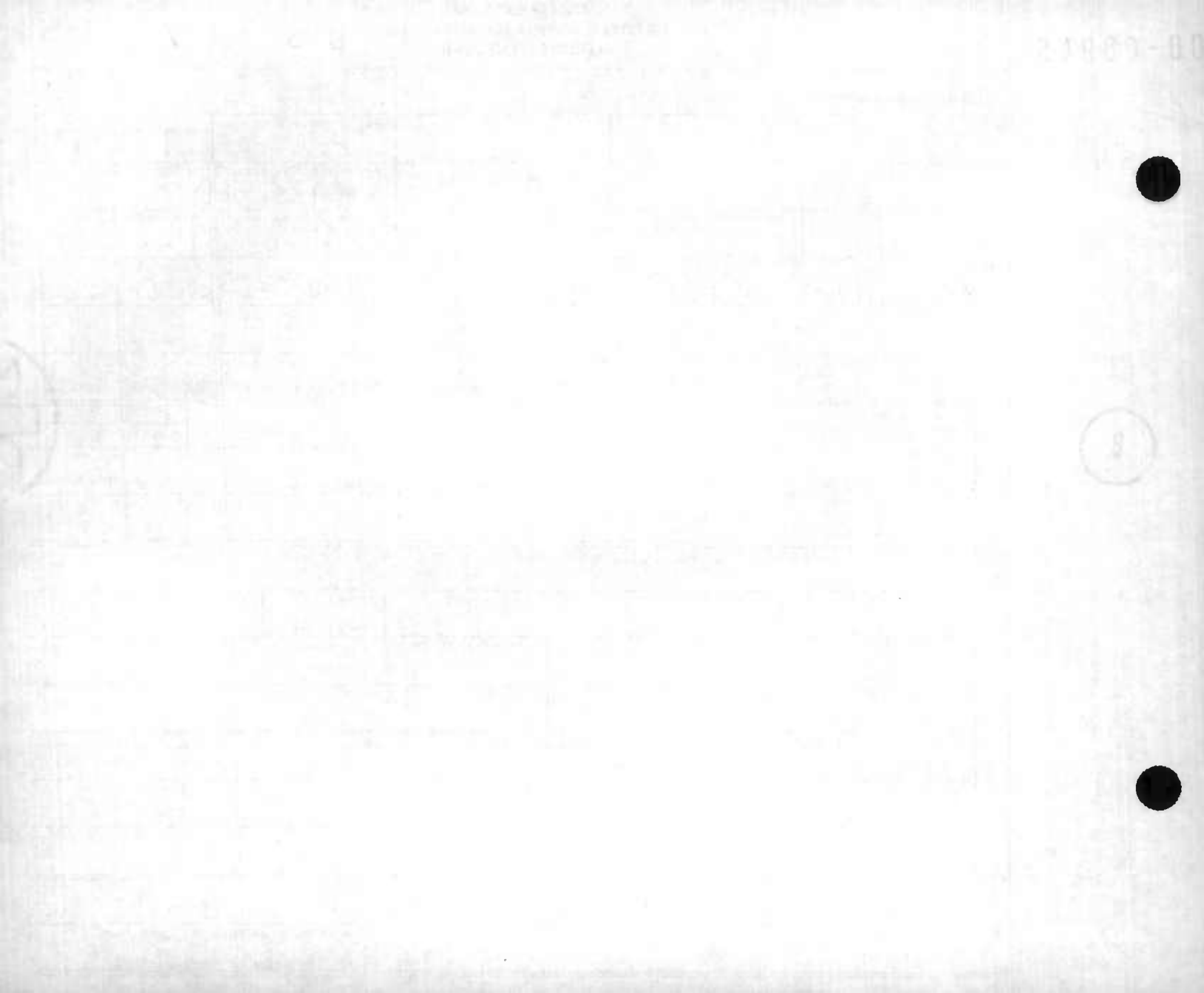
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 5 1 5
REG. NO. 13 15 39

1. DECEASED NAME (TYPE OR PRINT) Clarence S. Russell			2a. DATE OF DEATH MONTH DAY YEAR 6 7 86			2b. HOUR 08:50 AM			
3. SEX M		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 03 02 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD			13b. COUNTY HARFORD		13c. STREET ADDRESS / ZIP CODE 12906 FORK RD 21013				
14. FATHER'S NAME FIRST MIDDLE LAST Harry W. Russell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Isenock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-3940		17. INFORMANT ADDRESS Mrs. Berniece Russell, Baldwin, Md. 21013				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrical-mechanical dissociation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/7/86</u> , 19 <u>86</u> , to <u>6/7</u> , 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>6/7</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Douglas L. Mallory M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/7/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>S. Mallory</u>			22e. ADDRESS <u>N.H. Bldg. 10 Rm 10048 Bethesda, Md. 20205</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-10-1986		23c. NAME OF CEMETERY OR CREMATORY Fork U. Meth. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fork Baltimore Co. Md.		
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd., Kingsville, Md. 21087					25a. DATE REC'D. BY REGISTRAR JUN 11 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



00-08863

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Lillian Marie Sampson			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-5 86			2b. HOUR 9a M			
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 11 34	6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD 6-5 1986			7d. HOUR 10a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 148 Osborn Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 148 Osborn Rd. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Conley Trigg Gullion				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora Mae McCloud					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 28 3448		17. INFORMANT Family same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) <u>COPD - emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10i.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Luis E. Renjel</u>			TITLE (SPECIFY) Deputy MEDICAL EXAMINER					DATE SIGNED 6-5-86	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.			ADDRESS 464 Alliance St. Havre De Grace, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/9/86		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gdns.			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, PA, Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR JUN 9 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

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DHMH - 17
(VR A15 ME (5))

NOV 19 1944



Mr. J. Edgar Hoover

U. S. Department of Justice

Washington, D. C.

Dear Mr. Hoover:

I am writing to you regarding the

matter of the [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

[illegible] [illegible] [illegible]

00-10857

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 6 1 7 5 1 7 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAM SAMUELS					2a. DATE OF DEATH MONTH DAY YEAR 6-23-86					2b. HOUR 6:55 AM				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 31 14		6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.								
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISP.		12b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN FORK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6505 UPLAND ROAD 21051						
14. FATHER'S NAME FIRST MIDDLE LAST HARRY SAMUELS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE FRANK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT CHART		ADDRESS FAMILY RECORDS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE CARCINOMA OF 8mm DUE TO, OR AS A CONSEQUENCE OF (c) THE LUNG WITH BONE METASTASES										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from 6/6/86, to 6/23/86, that (1) (we) last saw the deceased alive on 6/23/86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE John P. Edwards				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P. EDWARDS				22e. ADDRESS FALLSTON, MARYLAND 21047										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6-26-1986		23c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH			23d. LOCATION CITY OR TOWN COUNTY STATE ROSDALE BALTO. MARYLAND					
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES				ADDRESS 8800 ROAD HARFORD				25a. DATE REC'D. BY REGISTRAR JUN 30 1986		25b. REGISTRAR'S SIGNATURE June Davidson-Harmon				

BP

00-09213

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 1 8
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Katherine Foreman Shenk				2a. DATE OF DEATH MONTH DAY YEAR June 2, 1986				2b. HOUR 6 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAR 29, 1929				6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD			
10. CITY OR TOWN OF DEATH Hartford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Grace Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY HARTFORD		13c. CITY OR TOWN PERRYMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1523 PERRYMAN RD., 21130			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN FOREMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA CHILUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 220-22-0342		17. INFORMANT ADDRESS W.L. SHENK, SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Sepsis, Bloody Discharge DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Renal Failure on Hemodialysis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Liver Dysfunction											
19a. DATE OF OPERATION 6-2-86				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-5-7 19 86 to 6-2 19 86 , that (I) (we) last saw the deceased alive on 6-2 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE nmj				DEGREE				22c. DATE SIGNED 6/1/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LATADN, DANIEL				22e. ADDRESS PO BOX 570 8 LAW ST, ALBANY NY 12001							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6/4/86		23c. NAME OF CEMETERY OR CREMATORY SPECUTIA CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE PERRYMAN HARTFORD MD	
24. FUNERAL DIRECTOR NAME ADDRESS TRAILING FUNERAL HOME, PA. AARDEEN, MD 21001-3331						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0



AKI

00-08450

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 5 1 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Heebeet L Sprankle			2a. DATE OF DEATH MONTH DAY YEAR 10-1-86			2b. HOUR 3²⁹ PM				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 23, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 69 YRS.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.				
12. CITY OR TOWN OF DEATH HAYRE DE GRACE			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1664 Perryville Rd. 21903	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Sprankle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Cox			16. ADDRESS 21903				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 10/11/34-10/10/37			16b. SOCIAL SECURITY NO. 215-16-5223		17. INFORMANT Dorothy J. Sprankle			18. ADDRESS 1664 Perryville Rd		

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK		hours.	
DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE MYOCARDIAL INFARCTION		days	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **SEVERE TRIPLE VESSEL CORONARY ARTERY DISEASE**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/1 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2003 ROCKSPRING Rd. FORT HILL MD. 21050			
22a. I certify that (I) (this hospital) attended the deceased from 6/1 1986 to 6/1 1986 , that (I) (we) last saw the deceased alive on 6/1 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Barry Wohl		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Wohl		22e. ADDRESS 2003 ROCKSPRING Rd. FORT HILL MD. 21050					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil Maryland	
24. FUNERAL DIRECTOR Lee A. Patterson & Son				25a. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) JUN 4 1986			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

215-100

215-100

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215-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, or other cause of death, the medical examiner must be notified at once.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 7 5 2 0	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Ann Stam						2a. DATE OF DEATH MONTH DAY YEAR JUNE 6, 1986			2b. HOUR 8:15 A.M.		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 14, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford County, MD.					
10. CITY OR TOWN OF DEATH Fallston (21047)		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 900 MONTE AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Automobile			
13a. STATE Maryland						13b. COUNTY Hartford Co.		13c. CITY OR TOWN Fallston (21047)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Rowan Gage						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Handeran					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 112-20-6719		17. INFORMANT (SON) 877-7692		ADDRESS 900 MONTE AVENUE Mr. Frederick A. Stam Fallston, Maryland (21047)					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE C-U-A DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED A.S.C.V.D.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED LESS THAN 1 HR. 1 1/2 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION —				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from 1-25-85 , 19 85 , to 6-4- , 19 86 , that (1) the lost saw the deceased alive on 5/30/86 , 19 86 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (1) the (did) not see the body after death.											
22b. SIGNATURE <i>H. P. Sidwell M.D.</i>						22c. DATE SIGNED JUNE 6, 1986		22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. P. Sidwell, M.D.			
22e. ADDRESS 401 Franklin Street, Bel Air, Maryland 21014											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE JUNE 7, 1986		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR <i>Joseph William Foster</i> <i>Empireville, Ind.</i>						25a. DATE REC'D. BY REGISTRAR JUN 11 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

8

ADVANCED A.2.C.V.D
MASSIVE C-U-D
CARDIO-ART. FAILURE

12 MONTHS
1 YR.
2 YRS
3 YRS

2130122 1-28-82
2130122 1-28-82

2-2-82

THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY
IT IS NOT TO BE USED FOR ANY OTHER PURPOSE
IT IS NOT TO BE USED FOR ANY OTHER PURPOSE

00-09824

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 5 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAVILLA L. STARNER			2a. DATE OF DEATH MONTH DAY YEAR JUNE 17, 1986		2b. HOUR 8:30A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 7, 1981		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY, MD.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE PA 13b. COUNTY DELAWARE 13c. CITY OR TOWN NEWTOWN SQUARE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 37 ROCKWOOD ROAD 19073					
14. FATHER'S NAME FIRST MIDDLE LAST ROSCO VERMILYA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST INA ANDERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 169 07 5244		17. INFORMANT ADDRESS MARIBELLE FISHER SAME AS #13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiovascular Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

End Stage Renal Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Intermittent Heart Disease, Cachexia, SIP Injury, Perforated Peptic Ulcer

19a. DATE OF OPERATION 5/6/86	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Peptic Ulcer	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) N/A.	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6/17 1986 to 6/17 1986 that (I) (we) last saw the deceased alive on 6/17 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Manuel M. Lazatin	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 17 JUNE 86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LAZATIN, MD		22e. ADDRESS 8 LAW STREET, ABERDEEN, MD. 21001	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 18 JUNE 86	23c. NAME OF CEMETERY OR CREMATORY CREMATION SPECIALISTS	23d. LOCATION CITY OR TOWN COUNTY STATE MEDIA, DELAWARE CO., PA.
24. FUNERAL DIRECTOR NAME ADDRESS VIDEON-GIBSON FUNERAL HOME, BROOMALL, PA. MITCHELL FUNERAL HOME, HAVRE DE GRACE, MD. 21078		25a. DATE REC'D. BY REGISTRAR JUN 18 1986	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DHMH - 10 50M 4/83
(VRA 15, 4)

00-101201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 7 5 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OLIVE M. SUDECK			2a. DATE OF DEATH MONTH DAY YEAR June 19, 1986			2b. HOUR 5:45 AM											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 12, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.											
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 507 Camelot Dr. 21014								
14. FATHER'S NAME FIRST MIDDLE LAST George Sheckels			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Spurry														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-7212		17. INFORMANT Mr. William Sudeck		ADDRESS Same as #13e											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) History of Hypertension PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION																	
										19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
										21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
										21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
										22a. I certify that the hospital attended the deceased on 6/22/86 , to 6/24/86 , that (1) first last saw the deceased alive on 6/22/86 , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (1) with did not view the body after death.							
22b. SIGNATURE <i>Nestor M. Carmona</i>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/19/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nestor M. Carmona, M.D.				22e. ADDRESS 6012 Harford Rd.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Md.											
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JUN 20 1986		25b. REGISTRAR'S SIGNATURE									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% Colloidal

356
00-09356

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

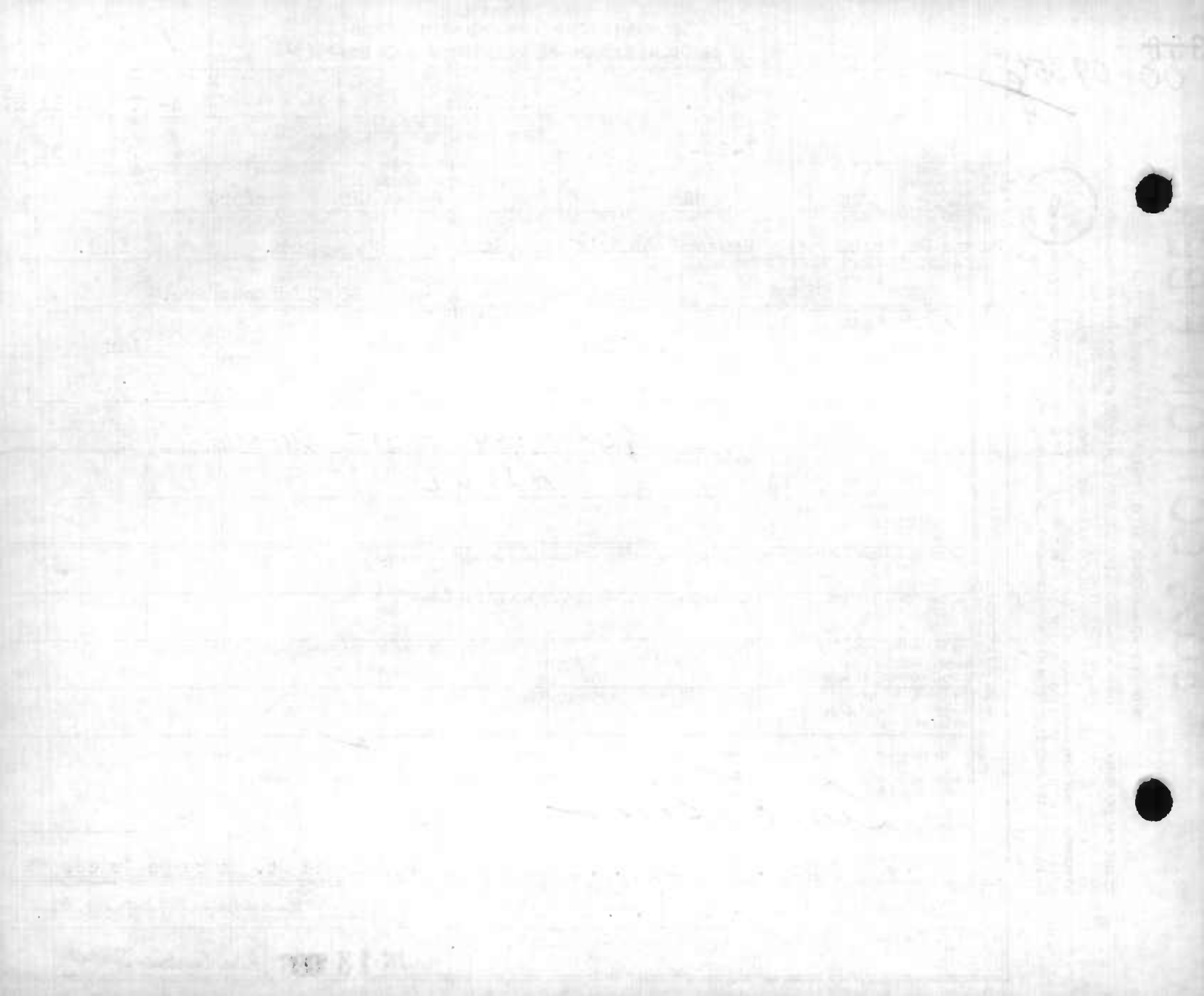
BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 7 5 2 3

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				2b. HOUR			
Robert		B.				Sullins		DATE ESTIMATED 6-7-1986				11:21 AM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR	
M	W	7-14-31		54 YRS.						6-7-1986				12:04 PM	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		10. BALTIMORE CITY OR COUNTY OF DEATH			
VA		USA										Harford MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Havre De Grace		Harford Memorial Hospital		Labor.		Ind.									
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS									
MD		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		33 Cliffmont Ave. 21213									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Robert		Virginia													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
Yes		212 28 2627		Garnet Sullins		27 Cox Rd.									
		Korea		Sister-in-law		Rising Sun, MD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
				Coronary Heart Disease		ASCVD									
						DUE TO, OR AS A CONSEQUENCE OF									
						DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		STATE	
		P.M. 19													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion							
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED											
Luis E. Renjel		M.D. Deputy													
EXAMINER'S NAME		ADDRESS													
(TYPE OR PRINT)		Luis E. Renjel, M.D.		464 Alliance St. Havre De Grace, MD											
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY		23g. STATE			
Cremation		6-12-86		R.A. Ferris		West Chester		Chester		Pa.					
24. FUNERAL HOME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE											
North East, Md.		JUN 13 1986		Julia Davidson											



00-10985

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

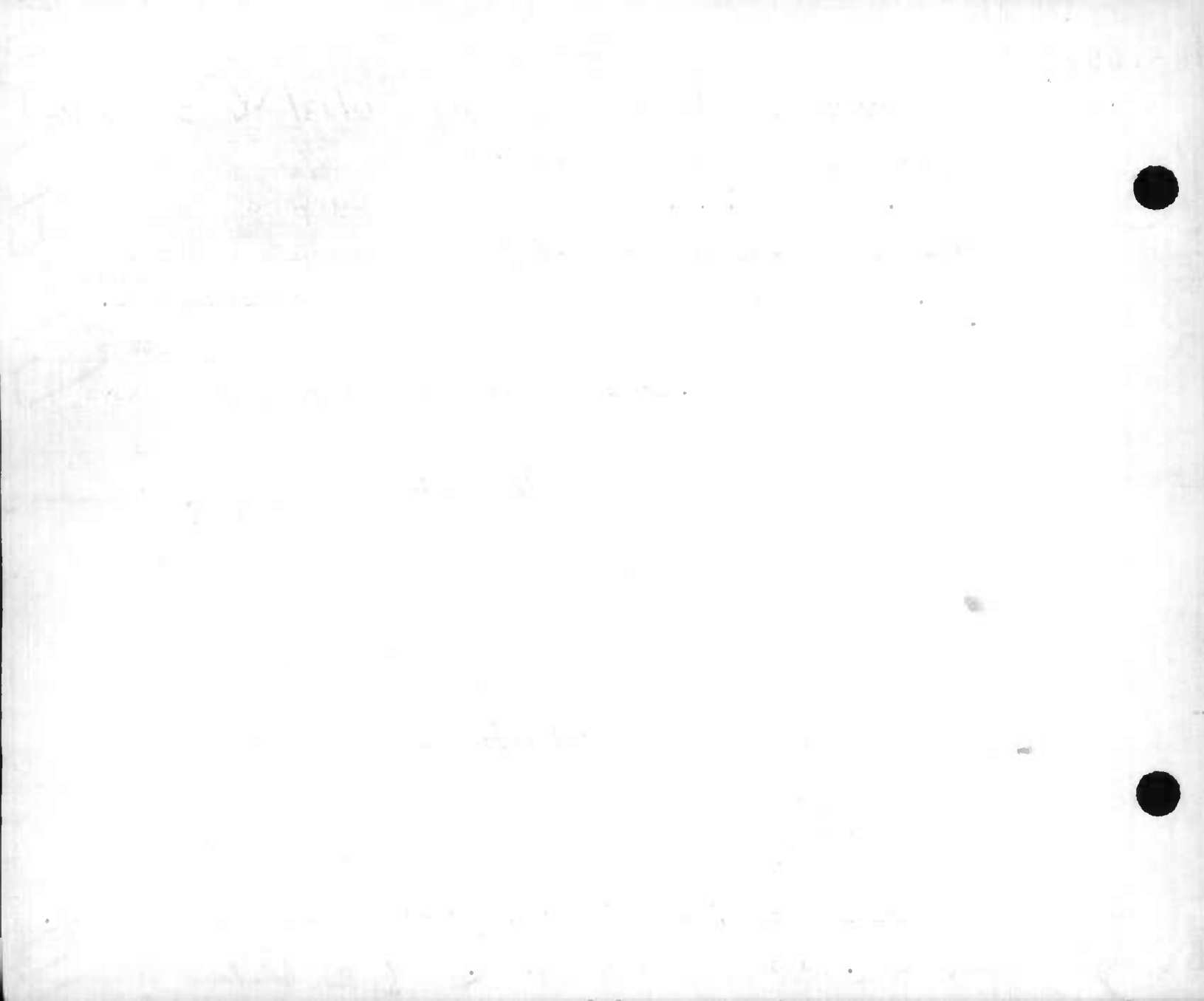
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 6 1 7 5 2 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Lilli Sweeney			2a. DATE OF DEATH MONTH DAY YEAR 6/23/86			2b. HOUR 1:38 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10. CITY OR TOWN OF DEATH Fallston.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4537 Norrisville Rd. 21161	
14. FATHER'S NAME FIRST MIDDLE LAST John Small Fullerton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Stump					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 177-10-4809		17. INFORMANT ADDRESS Margaret Gilbert same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASLVD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22/86</u> to <u>6/23/86</u> , that (I) (we) last saw the deceased alive on <u>6/22/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. N. NIK			22e. ADDRESS 2112 Bel Air Road						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/86		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Darby Delaware Pa.			
24. FUNERAL DIRECTOR NAME ADDRESS Benjamin W. Kurtz Jarrettsville, Md.						25a. DATE REC'D. BY REGISTRAR JUN 26 1986			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									



0-09496

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17525
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Audrey Bales Taylor			2a. DATE OF DEATH MONTH DAY YEAR June 10, 1986		2b. HOUR 12 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Harford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Emmett Bales		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nella P. Robinette		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT ADDRESS Churchville, MD 21028		17. INFORMANT P.W. Taylor, 2817 E. Medical Hall Rd.,		17. INFORMANT P.W. Taylor, 2817 E. Medical Hall Rd.,		17. INFORMANT P.W. Taylor, 2817 E. Medical Hall Rd.,	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Old myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6-10 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 308 S. Union Ave. Harford, Maryland			
22a. I certify that (I) (this hospital) attended the deceased from 6-10 1986 to 6-10 1986 , that (I) (we) last saw the deceased alive on 6-10 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE SANGT W. KIM				DEGREE MD		22c. DATE SIGNED 6/10/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANGT W. KIM				22e. ADDRESS 308 S. Union Ave. Harford, Md. 21078			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jun. 13, 1986		23c. NAME OF CEMETERY OR CREMATORY Harford Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen, Harford, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399				25a. DATE REC'D. BY REGISTRAR JUN 16 1986			
				25b. REGISTRAR'S SIGNATURE June Warden-Henderson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-08947

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 2 6
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Edison C.		MIDDLE C.		LAST Testerman		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								June 6, 1986		8:59 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR. 14, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 63		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SAND BLASTER		12b. KIND OF BUSINESS OR INDUSTRY SHIPYARD	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN WHITEFORD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1301 HEAPS ROAD 21160			
14. FATHER'S NAME FIRST MIDDLE LAST WINFIELD TESTERMAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA MAE BLEVINS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. WW2 246-28-2589		17. INFORMANT ADDRESS ETHEL L. TESTERMAN, WHITEFORD, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-31 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-31 , 19 86 , to 6/6 , 19 86 , that (I) (we) last saw the deceased alive on 6/6 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante M. Monakil, MD						DEGREE		22c. DATE SIGNED 6/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL, MD						22e. ADDRESS Havre de Grace, Md 21178					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-9-86		23c. NAME OF CEMETERY OR CREMATORY MT. VERNON		23d. LOCATION CITY OR TOWN COUNTY STATE WHITEFORD HARFORD MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS JOHN H. HARKINS, 600 MAIN STREET, DELTA, PA						25a. DATE RECD. BY REGISTRAR JUNE 9 1986					
						25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00-10700

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner should be notified.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 2 7
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVELYN E. THELEN			2a. DATE OF DEATH MONTH DAY YEAR 6-26-86			2b. HOUR 4:35 A.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 25 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH BEL AIR		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL AIR CONVALESCENT CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY READ's drug store	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3030 Chesterfield Avenue 21213			
14. FATHER'S NAME FIRST MIDDLE LAST ADAM STEIGERWALD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA CRESS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-20-0136			17. INFORMANT ADDRESS 10 Porter Dr. LESTER STEIGERWALD (NEPHEW) Abingdon Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized And Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Schizophrenia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Days Four yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/11, 19 83, to 6/26, 19 86, that (I) (we) lost saw the deceased alive on 6/25, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dudley Phillips MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/26/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dudley Phillips MD				22e. ADDRESS DARLINGTON MD 21034					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/28/86		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR SCHIMUNEK FUNERAL HOME, INC. 9705 Belair Rd., Balto. Md. 21236				25a. DATE REC'D. BY REGISTRAR JUN 27 1986		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

00-0100

1000000



00-08778

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 7 5 2 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		8:12 P M	
CLARENCE WILLIAM THOMAS		JUNE 3, 1986			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	71	IF UNDER 24 HRS	
		Oct. 8, 1914		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Hopwood, Pa.	USA		Harford County MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Bel Air	516 Red Pump Road		Bartender	Hotel	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Harford	Bel Air	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	516 Red Pump Road 21014
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Harrie J. Thomas		Gertrude — Minerd		265-10-3368	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
Yes WW II		Mrs. Margaret H. Thomas, 516 Red Pump Road		Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Squamous cell CARCINOMA of head + neck</u>					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE	
				4/11 86	
22a. I certify that (I) (this hospital) attended the deceased from 4/11/86 to 4/11/86, that (I) (we) lost the deceased on 4/11/86 and that in my opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE				22c. DATE SIGNED	
Joan P. Edwards, M.D.				6-4-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6-7-86		Bel Air Memorial Gardens Bel Air Harford Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUN 6 1986		Julia Davidson-Henderson	
Howard K. McComas III, Abingdon, Md. 21009					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

COMMERCIAL DISTRICT

NO 10

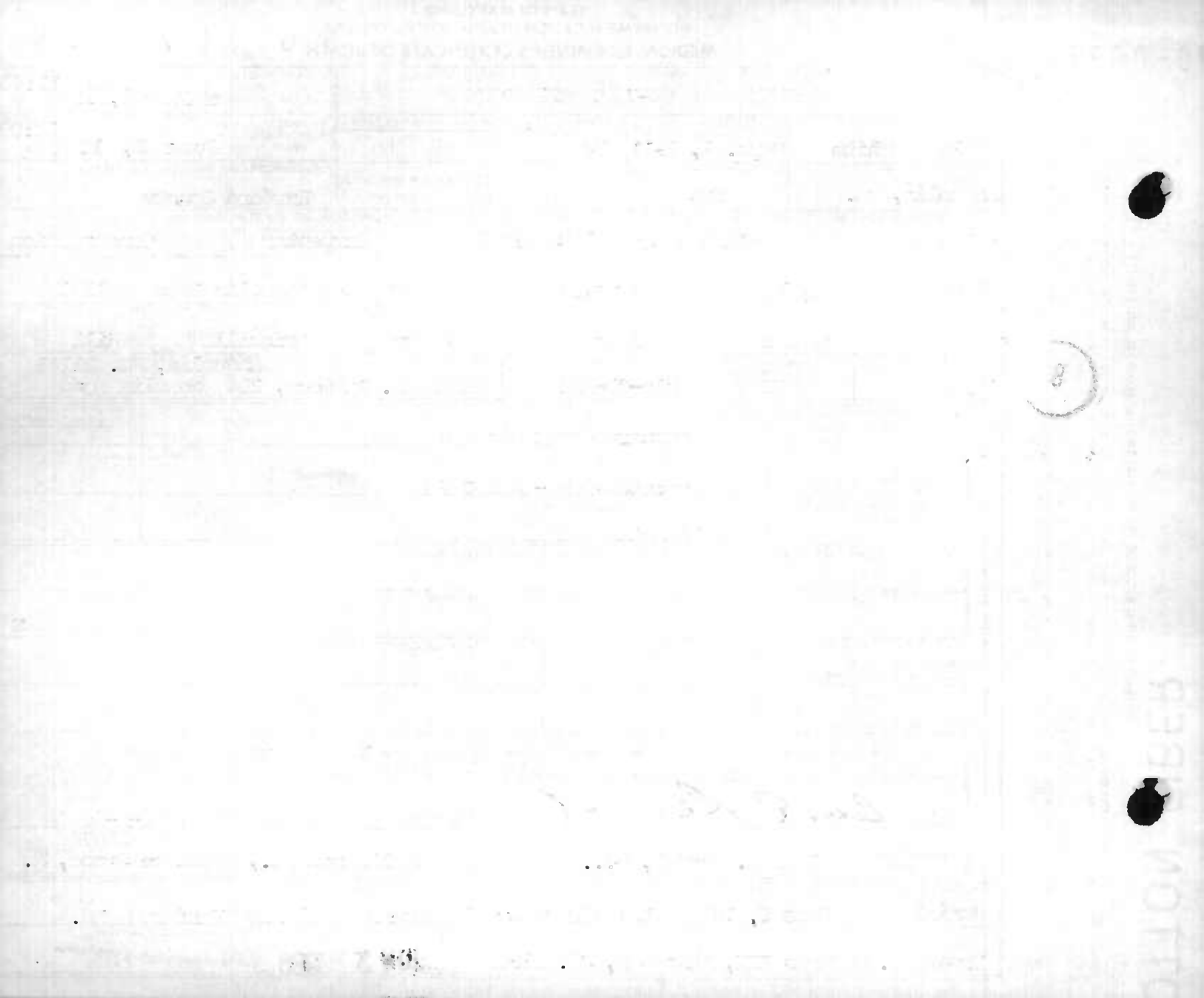
415-420

Descent of the river
from the top of the mountain
to the bottom of the valley

CHILKEN

POST CO.





00-09229

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 17530
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George R. Toliver			2a. DATE OF DEATH MONTH DAY YEAR June 11 1986			2b. HOUR 4 MIN A			
3. SEX MALE		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 10-24-05		6. AGE (IN YEARS LAST BIRTHDAY) 81		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) V.I.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.			
10. CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Hartford Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Railroad		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY HART.		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 413 Pulski Highway #21085	
14. FATHER'S NAME FIRST MIDDLE LAST Jerry Toliver				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA Shepard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 705-09-741		17. INFORMANT ADDRESS EVA Toliver 413 Pulski Highway #21085			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CH F DUE TO, OR AS A CONSEQUENCE OF, (b) ASVP. CAP. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) permanent pacemaker		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6-4 19 86 , to 6-11 19 86 , that (I) (we) last saw the deceased alive on 6-11 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. F. Lee				DEGREE M.D.		22c. DATE SIGNED 6/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. F. Lee				22e. ADDRESS Union Med. Clinic			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/14/86		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Bapt. Ch.		23d. LOCATION CITY OR TOWN COUNTY STATE Edgewood md.	
24. FUNERAL DIRECTOR NAME ADDRESS Betts Funeral Home 1129 N. Caroline St				25a. DATE REC'D. BY REGISTRAR JUN 12 1986		25b. REGISTRAR'S SIGNATURE John Barker	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified promptly.

00558

20X COTTON BULB

WATSON

00-10224

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8617531							
1 - FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys B. Tome					2a. DATE OF DEATH MONTH DAY YEAR 6 13 86			2b. HOUR 25 PM									
3. SEX Male Female Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 25 12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.											
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen. Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland										13b. COUNTY Harford		13c. CITY OR TOWN Street		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3624 Scarboro Rd., 21154	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Grove					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Chandlee												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		213-38-5157		17. INFORMANT ADDRESS Chris D. Tome, 3624 Scarboro Rd., Street, Md											
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Cancer of Rectum DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Renal Failure, Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Willard P. Amoss		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/13/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amoss				22e. ADDRESS 2303 Bel Air Rd, Fallston Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/17/86		23c. NAME OF CEMETERY OR CREMATORY Shenbergers Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE New Bridgeville, York, Pa.											
24. FUNERAL DIRECTOR NAME John H. Harkins, 600 Main St., Delta, Pa., 17314				25a. DATE REC'D. BY REGISTRAR Jun 16 1986		25b. REGISTRAR'S SIGNATURE John Davidson											



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Handwritten signature or initials at the bottom left of the page.

00-10226
75

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 7 5 3 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Peter I. Vaccarino			2a. DATE KNOWN OF DEATH ESTIMATED 6-13-86			2b. HOUR 4:30 a		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 5 DAY 6 YEAR 31	6. AGE (IN YEARS) (LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 6-13-86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Whiteford		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2939 Whiteford Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Repairman		12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. STATE MD		13b. CITY OR TOWN Harford		13c. CITY OR TOWN Whiteford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST Joseph MIDDLE LAST Vaccarino		15. MOTHER'S MAIDEN NAME FIRST Carmela MIDDLE LAST Danna		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. 213 26 6330		17. INFORMANT Helen E. Vaccarino Wife		17. ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Luis E. Renjel		TITLE (SPECIFY) Deputy					DATE SIGNED 6-13-86	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.		ADDRESS 464 Alliance St. HavreDe Grace, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/16/86		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION CITY OR TOWN Pylesville COUNTY Harford STATE MD		
24. FUNERAL DIRECTOR NAME John Harkins ADDRESS 600 Main Street Delta, PA 17314				25a. DATE REC'D. BY REGISTRAR JUN 18 1986		25b. REGISTRAR'S SIGNATURE Julia...		

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

POX COLLOID LIBRARY

LIBRARY



00-11021

8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOUR PM 3. RETURN PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR AIS ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17533

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rose Whiteford				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 6-19 1986				2b. HOUR 8:30 a.m.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11 26 12	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD 6-19 1986		2d. HOUR 11 10a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2730 Chestnut Hill Rd. 21050	
14. FATHER'S NAME FIRST MIDDLE LAST William H. German				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosella Birckhead					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 213 28 1425		17. INFORMANT Henry (husband) ADDRESS same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. ASCVD (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Luis E. Renjel				TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 6-19-86	
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel, M.D.				ADDRESS 464 Alliance St. HavreDeGrace, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-23-1986		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Co. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS E.F. LASSAHN, 11750 Belair Rd. King'sville, MD 21087				25a. DATE REC'D. BY REGISTRAR JUN 25 1986		25b. REGISTRAR'S SIGNATURE Luis E. Renjel			

1-1100-1

MEMO NOTED X-00

WINTER

00-08895

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17534

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH Roland WICK			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 6 19 86		2b. HOUR 3:20A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 12, 1944	6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 1986
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY		10. CITY OR TOWN OF DEATH Fallston			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Hotel-Tavern Operator
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Joppatowne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 734 Falconer Road, #21085
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - - - - Wick, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Susan Baxter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-42-7807		17. INFORMANT ADDRESS Joppatowne, Md. Joan R. Wick, 734 Falconer Road, 21085	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt chest trauma 8/22 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00xx 6/6 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of motorcycle which impacted auto.	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt#40 and Gateway, Joppa, Harford County, MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED June 6, 86	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jun 1986		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Co., MD.		25a. DATE REC'D. BY REGISTRAR JUN 9 1986			
24. FUNERAL DIRECTOR NAME Martin D. Lawson		ADDRESS 10 W. Padonia Road,		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86
REG. NO.

17535

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Violet Deborah Wiggins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 1 1986</i>		2b. HOUR <i>12:20 PM</i>	
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 1896</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		8. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>		
12. CITY OR TOWN OF DEATH <i>Harford</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harford Memorial Hospital</i>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <i>MD</i>		15b. COUNTY <i>CECIL</i>		15c. CITY OR TOWN <i>Rising Sun</i>		
16. FATHER'S NAME FIRST MIDDLE LAST <i>JAMES COLLEY</i>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MARJORIE BARROW</i>		18. STREET ADDRESS / ZIP CODE <i>105 COOPER ST. 21911</i>		
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		20. SOCIAL SECURITY NO. <i>213-20-3605</i>		21. INFORMANT <i>Joseph W. Wiggins</i>		
22. ADDRESS <i>Biggs Hwy Rising Sun MD</i>		23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute coronary insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension non hypertensive</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>diabetes mellitus, arteriosclerotic cardiovascular</i>						
24. DATE OF OPERATION <i>5-29-86</i>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>6-1-86</i>		26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>5-29-86</i>		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
30. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION CITY OR TOWN COUNTY STATE <i>Harford MD</i>		
33. I certify that (I) (this hospital) attended the deceased from <i>5-29-86</i> to <i>6-1-86</i> , that (I) (we) last saw the deceased alive on <i>6-1-86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
34. SIGNATURE <i>John D. ...</i>		35. DEGREE <i>MD</i>		36. DATE SIGNED <i>6/1/86</i>		
37. PHYSICIAN'S NAME (TYPE OR PRINT) <i>AMAKHAN M.D.</i>		38. ADDRESS <i>319 So. Union Ave Harford Md</i>				
39. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		40. DATE <i>6-5-86</i>		41. NAME OF CEMETERY OR CREMATORY <i>WEST MOUNTAIN</i>		
42. LOCATION CITY OR TOWN COUNTY STATE <i>COLONA CECIL MD</i>		43. DATE REC'D. BY REGISTRAR <i>JUN 4 1986</i>				
44. FUNERAL DIRECTOR <i>Richard L. Goodie</i>		45. ADDRESS <i>Rising Sun, Md</i>		46. REGISTRAR'S SIGNATURE <i>John Davidson-Henderson</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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0-10573

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8617536
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Man/ Alice Young		6/25/86		0053	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		10 11 15	
6. AGE (IN YEARS (LAST BIRTHDAY))		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
70 yr YRS		Bel Air, Md.		USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
		Harford		Seamstress	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston Gen Hosp		Seamstress		Sewing Factory	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Harford		Bel Air	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
James Rockwell		Christina (Mm) Unkart		no	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONICITY of the LUNG</u> 4 mon DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Ella L. Stifler, 1600 S. Tollgate Road, Bel Air					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
22a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET CITY OR TOWN COUNTY STATE	
23a. I certify that (I) (this hospital) attended the deceased from <u>6/20/86</u> to <u>6/25/86</u> , that (I) (we) lost saw the deceased alive on <u>6/20/86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.		23b. SIGNATURE		23c. DATE SIGNED	
24a. PHYSICIAN'S NAME (TYPE OR PRINT)		24b. ADDRESS		24c. DATE SIGNED	
Howard K. McComas III		21047			
25a. BURIAL, CREMATION, REMOVAL		25b. DATE		25c. NAME OF CEMETERY OR CREMATORY	
Burial		June 27, 1986		Bel Air Memorial Gardens, Bel Air Harford Md.	
26a. FUNERAL DIRECTOR		26b. DATE REC'D. BY REGISTRAR		26c. REGISTRAR'S SIGNATURE	
Howard K. McComas III, Abingdon, Md. 21009		JUN 26 1986			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP.

